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HEALTH CARE FOR UNEMPLOYED WORKERS

JULY 25, 1983.—Ordered to be printed

Mr. DOLE, from the Committee on Finance, submitted the following

REPORT

together with

ADDITIONAL VIEWS

[To accompany S. 951]

I. BACKGROUND AND PURPOSE OF THE LEGISLATION

As the result of high levels of unemployment in the United States, many workers and their families have lost their employment-based group health benefits and their employers' contributions toward the costs of that important protection. Group health benefits are relatively inexpensive for many employees (and their dependents) because group coverage generally costs less than individually purchased insurance and because employers ordinarily pay most or all of the premiums. Most workers who become unemployed for a period of more than a month or two lose these benefits, and must seek more expensive (or less adequate) coverage on a non-group basis. Moreover, the unemployed workers must also pay the entire cost of this protection just when they are confronted with a significant reduction in their incomes.

In general, the unemployed who lose employer-based health insurance protection are unable to obtain coverage under existing public health care programs that are targeted toward other specific population groups. The Medicare program, for example, is limited to the aged and the seriously disabled. State Medicaid programs provide protection for many, but not all, of the Nation's poor, but the eligibility requirements of those programs preclude most unem-

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ployed workers and families with such workers from obtaining program benefits. Still other publicly sponsored programs, such as those run by the Veterans' Administration, can assist only selected numbers of those who lose employment-based health benefit protection.

The loss of group health insurance for those who have lost their jobs is not a new problem, but the growth in the number of workers who have lost their jobs and the duration of such unemployment is unprecedented in recent years.

The Committee bill is intended to address the urgent needs of the unemployed and their families for health benefit protection during their period of economic difficulty. The bill establishes an optional 2-year Federal-State program through which States are entitled to receive financial assistance to provide certain health benefits for unemployed persons receiving unemployment compensation and certain workers who have recently lost such benefits. The bill also makes certain changes in the tax law which are designed to alter private employer health benefit plans.

Under the program, $750 million in Federal funds would be provided for program benefits for each of two 12-month periods beginning August 1, 1983. For each 12-month period, an additional $150 million would be provided to cover the costs of program administration.

II. General Explanation

Title I—Health Care for Unemployed Workers

GRANTS TO STATES

(Section 101 of the bill)

Section 101 of the bill amends title XX of the Social Security Act to establish a temporary, two-year program of Federal funding to the States (including the District of Columbia, Puerto Rico and the Virgin Islands) for the purpose of providing health care services to certain unemployed individuals and their immediate families. Under the bill, each State is entitled to Federal matching payments toward the costs of providing health benefits up to a maximum amount allotted to each State under a distribution formula included in law. Funds would be allocated to the States on the basis of two factors: (1) the number of unemployed persons insured under the unemployment compensation system in each State in relation to the total number of such unemployed in all States and, (2) the number of persons unemployed for 26 weeks or more in each State in relation to the total number of such persons in all States.

1. Eligibility for benefits

Under the bill, eligibility for benefits is linked to the Federal/State unemployment compensation system. Within very broad limits, each State may choose groups of persons and their immediate families who are to be covered, the duration of such coverage, and the duration of the program itself. However, coverage may not be provided to individuals (and their immediate family members) unless they (1) are receiving regular State, extended, or Federal

supplemental unemployment compensation benefits, or unemployment benefits paid by the Railroad Retirement Board under the Railroad Unemployment Insurance Act; and (2) had been enrolled in an employer group health benefits plan when they last became eligible for unemployment compensation benefits. States would be expected to use the broadest possible determination of proof that potentially eligible persons had been enrolled in a group plan while previously employed. Eligibility is also extended under the bill to those jobless individuals (and their immediate family members) who received but exhausted any unemployment compensation benefits within the prior six months. By including those eligible for railroad unemployment benefits among those eligible to participate in the program, it is hoped that the State will give these individuals the same opportunity to participate as all other unemployed individuals in the State.

Persons eligible for benefits under Medicare or a State's Medicaid program and individuals who are, or who could be, covered under a group health plan for which a contribution is made by an employer, union or entity other than the individual would be excluded from eligibility under the program. The Committee believes that the limited funds available to provide emergency health benefits for the unemployed should supplement and not supplant any other sources of benefit protection. The Committee's bill also provides for changes in the design of most private employer and other group health plans to facilitate coverage for workers or their spouses (and certain other family members) who have lost health benefits because of unemployment.

States would be required to establish income standards for individuals and for families as a condition of eligibility for benefits under the State's program. At a minimum, such standards would have to exclude individuals or families with incomes equal to or greater than the State median income by family size as published by the Secretary of Labor. The State would be entirely free to establish more stringent income standards if it chooses, and would be given maximum flexibility in implementing such standards. The States would determine for themselves the declaration or proof of income to be used in such standards, the type of income to be included, and the time period over which the income is to be measured.

The Secretary of Health and Human Services could waive application of the income standard requirement in particular States at the request of the State to the extent that special circumstances make the use of an income test unnecessary.

For individuals the State chooses to cover under the program, coverage would begin no sooner than 6 weeks following the week in which the individuals are first entitled to unemployment compensation benefits and apply for health benefits under the program. Coverage would end 6 months after eligible individuals were no longer entitled to unemployment compensation benefits (or for a lesser period at the option of a State), or one month after reemployment, whichever occurs first. Coverage could not be provided with respect to any services rendered prior to August 1, 1983, rendered to an individual before such person is eligible under the State pro-

gram or rendered in connection with inpatient services provided in a continuous period that began before such date or such eligibility.

2. Benefits provided

Under the bill, benefits would be limited to: inpatient hospital services; emergency outpatient hospital services; routine and emergency physician services, including those provided in health clinics and hospital outpatient departments, but excluding those provided in connection with nursing home care; prenatal, delivery, and postpartum care (which may be provided by a hospital, physician or clinic); laboratory, x-ray and radiation therapy services; and the services of a nurse midwife. States could also cover home health benefits where the States determine they are cost effective. No coverage would be available for prescription drugs or biologicals, except those provided on an inpatient hospital basis. No cash payments may be made to any individual participating in the program. If a State provides any benefits, it must at a minimum include ambulatory and hospital services. In no case, however, may the benefits offered under this program exceed those under a State's Medicaid program for the categorically needy. Within these limits, States are free to determine the services to cover and the amount, duration and scope of covered services.

3. Contributions and cost-sharing requirements

Participation by eligible individuals in a State's program of health benefits for unemployed workers is entirely voluntary. For those electing to enroll in the program, a State could impose an enrollee contribution of up to 8 percent of an individual's weekly unemployment compensation benefit payment. The State could vary such contribution amounts for individual and family coverage and by provider arrangement.

States would also be allowed to impose cost sharing requirements on outpatient services covered under the program, except that such requirements could not, on average, be expected to exceed 5 percent of the State's average monthly unemployment compensation payment and could not be required for prenatal, delivery, and postpartum services. With respect to inpatient hospital services covered by the program, the State could require cost sharing up to the maximum limits permitted under the Federal Medicaid program. At a minimum, if the States require any cost sharing the State must impose cost-sharing requirements at least equal to those that apply under its own Medicaid program.

No deductible or coinsurance amounts could be imposed by the State, until it conducts public hearings which provide adequate notice and opportunity for public participation in connection with such imposition. Subject to the overall limitations described above, a State could also vary the amount of deductibles and coinsurance payments for different groupings of eligible individuals, different types of services, different provider arrangements and various coverage periods.

All enrollee contributions and cost-sharing revenues must be used to offset the State share of program benefit costs, to provide additional covered services or to provide additional periods of coverage to eligible individuals.

4. Administration

The bill requires that State unemployment offices be responsible for determining qualifications for coverage under the new program. Upon becoming eligible for unemployment compensation benefits, the office will inform an individual of his eligibility for health care coverage (including the effective date of such coverage) under the State program, and that he has up to four weeks during which to enroll, if he elects to do so. A potentially eligible person will also be informed that he may qualify under a spouse's health benefits plan and, if so, that consideration should be given to enrolling in the spouse's plan. An unemployed individual who can enroll in a spouse's health plan (whether he elects to do so or not) is not eligible to enroll under the State program. An otherwise eligible person who declines the opportunity to enroll in the State program or who voluntarily terminates his participation after once having enrolled may not reenroll unless he subsequently becomes eligible for unemployment compensation benefits for a new benefit year as determined under the State's unemployment compensation law.

Any State which chooses to cover under its program individuals residing in such State who are or were receiving railroad unemployment compensation, may enter into an agreement with the Railroad Retirement Board under which the Board would notify those unemployed railroad workers, who may be eligible under the program, of the availability of the program. The Board would then furnish the State agency making eligibility determinations with such information as the State agency may require in order to make eligibility determinations with respect to such unemployed railroad worker. The State would be expected to reimburse the Board for administrative costs incurred under such agreement.

If a State elects to require that program participants make a financial contribution as a condition of enrollment in the State program, the State may deduct the amount of such contribution from any unemployment compensation payment to which an individual enrollee is entitled. Arrangements could also be made for those individuals no longer receiving benefits, to pay in some other fashion.

Any State which chooses to cover under its program individuals who are or were receiving railroad unemployment compensation may enter into an agreement with the Railroad Retirement Board under which the Board deducts the appropriate contribution and then transfers such amounts to the State.

The Committee intends that States be given as much flexibility as possible in the administration of the benefits portion of the program. Therefore, a State would be given the option of designating the State Medicaid agency to administer the payment of health benefits under the program, or the State could make arrangements with one or more other public or private entities for the purpose of making benefit payments to health care providers, practitioners and suppliers of services. A State may also elect to provide benefits through prepaid capitation arrangements and, if so, it may enter into agreements with organizations that provide benefits on a capitated basis without regard to the limitations of section 1903(m) of the Social Security Act. However, regardless of whatever arrangements a State adopts to administer program benefits on behalf of

the unemployed, payments for covered services may not exceed the amounts paid for the same services when provided under the State's medical assistance (Medicaid) program.

5. Federal financial participation

Under the bill, $750 million in Federal funds is provided for program benefits for each of two 12-month periods beginning August 1, 1983. An additional $150 million would be provided for each 12-month period to cover the costs of program administration. Funds to be provided to the States participating in the new program will be calculated in two steps: (1) by means of an allocation formula that distributes the federal funds available among the States and (2) a formula which determines the rate at which payments are made.

(a) Allocation formula

The $750 million in Federal funds for benefits would be distributed to the States on the basis of an allotment formula which takes into account: (1) The number of insured unemployed in a State in relation to the total number of insured unemployed in all States; and (2) the number of persons unemployed for 26 weeks or more in each State in relation to the total number of such persons in all States.

Such allotments would be made at the beginning of the two 12-month periods on the basis of the most recent 12-month moving average in the case of a State's insured unemployment population and the population of persons unemployed within each State for 26 weeks or longer, each figure as determined and reported by the Department of Labor.

An allotment for benefits for the 12-month period beginning August 1, 1984, will remain available to pay for benefits of those who are enrolled in a State's program on July 31, 1985, until the eligibility of such individuals terminates, or January 31, 1986, whichever is earlier. At the end of either of the two 12-month periods funds allocated to any State that has not established a program of health care for unemployed workers would be realloted to States that do establish programs.

The allotments available to each State are shown in Table I. These estimates are based on the most recent estimates of the number of insured unemployed and the number of unemployed for more than 26 weeks.

(b) Federal matching rate

From each State's allotment, Federal matching funds would be available to pay for services covered under each State's program. Federal matching funds would be available to those States with an insured unemployment rate (IUR) of 2 percent or greater and opting to participate at a rate of 100 percent through January 31, 1984. Thereafter, beginning February 1, 1984, for those States with IUR's equal to or greater than 2 percent and who elect to participate, the following matching rates would apply:

States with IURs equal to or greater than 2 percent and less than 3 percent would be matched at 50 percent.

States with IURs equal to or greater than 3 percent and less than 4 percent would be matched at 65 percent.

States with IURs equal to or greater than 4 percent and less than 5 percent would be matched at 80 percent.

States with IURs equal to or greater than 5 percent would be matched at 95 percent.

For any State with an IUR greater by 20 percent than the State's average IUR for the last 2 years, the Federal match rate would be increased by 15 percentage points, except in no case would the rate exceed 95 percent. State IURs would be computed on the basis of a 12-month moving average.

Any State that qualifies for Federal matching funds at 50, 65, 80, or 95 percent will continue to receive such percentage as specified for not less than a 6-month period, unless it subsequently qualifies for a higher percentage, in which case the higher percentage will apply in such State for the remainder of the 6-month period. A State may requalify for a particular higher matching percentage upon reaching the required rate of insured unemployment after the end of any individual 6-month period. No 6-month period will extend beyond July 31, 1985.

A State may continue to enroll new eligible individuals in its program during any week in which, on the basis of the most recent 52-week moving average, its rate of insured unemployment is 2 percent or more. If the State qualifies to continue to enroll new persons in accordance with this requirement, such qualification will continue for a period of not less than 6 months. The State may requalify at the end of any 6-month period upon reaching the required rate of insured unemployment. No 6-month period may extend beyond July 31, 1985. During any period in which a State cannot enroll new eligible persons (i.e., its IUR has dropped below 2 percent), the State may continue to pay benefits on behalf of previously enrolled individuals until their eligibility expires, or, if sooner, January 31, 1986.

On the basis the most recent numbers of insured unemployed in each of the States, the Federal funds matching rates applicable in each State are shown in Table I:

TABLE I.—HEALTH BENEFITS FOR THE UNEMPLOYED [1]

	Percentage 52-week insured unemployment rate	Percent of prior 2 years	Federal allocation	Federal match (percent)	State match (dollars)
Alabama	5.59	126	$15,956,625	95	$839,823
Alaska	7.07	97	1,505,513	95	79,238
Arizona	4.23	161	6,790,238	95	357,381
Arkansas	5.68	119	5,735,701	95	301,879
California	5.28	131	84,866,438	95	4,466,656
Colorado	3.39	156	6,173,663	80	1,543,416
Connecticut	3.49	125	7,787,138	80	1,946,785
Delaware	3.26	92	1,542,113	65	830,368
District of Columbia	3.75	150	2,380,913	80	595,228
Florida	2.54	134	16,776,038	65	9,033,251
Georgia	3.25	128	11,602,275	80	2,900,569
Hawaii	3.42	111	1,816,200	65	977,954
Idaho	6.74	127	2,891,813	95	152,201
Illinois	5.23	115	51,006,826	95	2,684,571
Indiana	4.74	123	22,064,101	95	1,161,269
Iowa	4.48	132	8,414,138	95	442,850
Kansas	4.13	155	5,570,851	95	293,203
Kentucky	5.91	116	10,782,000	95	567,474
Louisiana	5.29	182	10,927,988	95	575,157
Maine	4.76	107	2,805,713	80	701,428
Maryland	4.24	127	12,435,713	95	654,511
Massachusetts	3.90	113	17,025,825	65	9,167,751
Michigan	6.66	96	54,508,688	95	2,868,879
Minnesota	4.08	136	11,970,188	95	630,010
Mississippi	6.03	140	8,622,150	95	453,798
Missouri	4.29	105	14,484,638	80	3,621,160
Montana	5.15	118	2,143,763	95	112,830
Nebraska	2.95	139	2,776,688	65	1,495,140
Nevada	4.70	132	3,093,151	95	162,797
New Hampshire	2.85	127	1,852,426	65	997,460
New Jersey	4.54	100	22,660,575	80	5,665,144
New Mexico	4.27	148	2,926,200	95	154,011
New York	3.85	108	47,407,126	65	25,526,912
North Carolina	4.37	133	16,510,688	95	868,984
North Dakota	3.68	127	1,095,600	80	273,900
Ohio	5.64	118	54,291,075	95	2,857,426
Oklahoma	3.62	223	4,533,600	80	1,133,400
Oregon	6.62	111	12,491,063	95	657,425
Pennsylvania	7.02	141	55,292,250	95	2,910,120
Rhode Island	5.59	107	3,329,513	95	175,238
South Carolina	5.24	132	10,453,313	95	550,175
South Dakota	2.32	116	942,150	50	942,150
Tennessee	4.71	112	14,992,725	80	3,748,181
Texas	2.55	199	18,905,513	65	10,179,891
Utah	4.97	151	3,316,575	95	174,557
Vermont	5.12	121	1,345,913	95	70,838
Virginia	2.33	113	10,923,938	50	10,923,938
Washington	6.48	126	19,053,938	95	1,002,839
West Virginia	8.27	143	9,603,451	95	505,445
Wisconsin	5.92	115	22,362,075	95	1,176,952
Wyoming	4.67	265	1,074,226	95	56,538
Puerto Rico	8.60	106	10,447,763	95	549,882
Virgin Islands	4.67	131	293,476	95	15,446
Total			750,000,000		120,734,429

[1] Based on most recent data available (June 18, 1983).

(c) Funds for administration

The Secretary of Health and Human Services is authorized to make payments for administrative expenses incurred in carrying out the program in an amount not to exceed $150 million for each of the two 12-month periods beginning on August 1, 1983, and August 1, 1984. The bill specifies that $70 million of the $150 million in each period be made available to the State agencies administering the program of benefits and the remaining $80 million to the Department of Labor for payment to the State unemployment compensation agencies and to the Railroad Retirement Board for functions performed in connection with the program. The payments to the State agencies administering the program of benefits will be made on the basis of the same allotment formula used to allot Federal funds for benefits among the States (i.e., the number of insured unemployed in each State and the number of persons unemployed for 26 weeks or more). The payments to the State unemployment offices made by the Department of Labor will be made in accordance with the same distribution formula presently used in connection with administering the State's unemployment compensation program. The funds allocated for administration are not subject to a matching requirement.

Payments authorized for administrative expenses may continue to be made with respect to any program costs incurred after January 31, 1986.

6. Other provisions

(a) Reports to the Secretary

Any State that establishes a program of health care for unemployed workers is required to report to the Secretary on June 1, 1984, on the program's implementation and impact. Any State which carries out a program for any period after January 31, 1984 would also be required to submit a final report in March 1986 upon expiration of its program. The form and content of such reports would be determined by the Secretary.

(b) Coordination of benefits

States are required under the bill to provide that the payment for any services received by an individual under the program will be secondary to, and reduced by the amount of, any other payment which is or could be made with respect to such services under any other health plan or public program, or from a third party (including any workmen's compensation law or plan, any automobile or liability insurance policy or plan, including a self-insured plan, and any no fault insurance). The State must also require each individual enrolled in the program to assign all rights to such payments as he may have to the State as a condition of enrolling in the program.

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OPEN ENROLLMENT REQUIRED FOR EMPLOYEES WITH UNEMPLOYED SPOUSES

(Section 102 of the bill)

The committee amendment adds a new subchapter B to chapter 41 of the Internal Revenue Code. Under this amendment, employers with ten or more employees are required to provide a period of open enrollment in the employee health plan for a married worker, if the worker's spouse is laid off or involuntarily separated (other than for cause or mandatory retirement), and the worker was or is eligible to enroll in the health plan. The open enrollment period is the thirty day period which begins on the date the worker's spouse is notified that he or she has become eligible for unemployment compensation. The terms and conditions of an enrollment during a qualified open enrollment period generally must be the same as those applicable for enrollments for new employees. However, the group health plan is not required to allow an already covered employee to elect a higher level of benefits during the qualified open enrollment period and any enrollment need not take effect until the spouse loses eligibility for coverage under his or her former employer.

The committee amendment provides that if an employer fails to provide an open enrollment opportunity, such employer is subject to an excise tax equal to $500 for each employee who meets the requirements but is unable to change or initiate coverage. The penalty applies to both nonprofit organizations and taxable entities. The excise tax penalty does not apply to Federal or State governments. However, States would not be eligible to receive Federal funds under the new public program unless all State employees are provided the same open enrollment opportunity.

Effective date.—The provision is effective with respect to spouses who are involuntarily laid off or separated more than 60 days following enactment unless the existing group health plan was subject to a collective bargaining agreement. In such cases the effective date of the provision would be the date on which the collective bargaining agreement expired (determined without regard to any extensions agreed to after the date of enactment).

STUDY OF PRIVATE SECTOR HEALTH CARE COVERAGE FOR THE UNEMPLOYED

(Section 103 of the bill)

The committee amendment requires the Secretary of the Department of Health and Human Services to conduct a study of private sector health care coverage for unemployed workers. The study is to include estimates of the costs which would be incurred by employers in providing continuing health care coverage for various time periods and at various contribution levels by former employees (including a zero contribution level).

Effective date.—The Secretary is required to report the results of the study to Congress not later than January 1, 1985, including any legislative recommendation.

Title II—Medicare and Medicaid Provisions

REPEAL OF LIMITATIONS ON PART B PREMIUM INCREASES

(Section 201 of the bill)

Present law.—By law, the Secretary of Health and Human Services has been required to calculate each December the increase in premiums of those who elect to enroll in the Supplementary Medical Insurance (or Part B) portion of the Medicare program. The new premium rates have been effective on July 1 of the year following the year in which the calculation was made. Ordinarily, the new premium rate is the lower of: (1) an amount sufficient to cover one-half of the costs of the program for the aged or (2) the current premium amount increased by the percentage by which cash benefits are increased under the cost-of-living adjustment (COLA) provisions of the social security programs. Premium income, which originally financed half of the costs of Part B, had declined—as the result of this formula—to less than 25 percent of total program income. The "Tax Equity and Fiscal Responsibility Act of 1982" (TEFRA) temporarily suspended the COLA limitation for two one-year periods, beginning on July 1, 1983. During these periods, enrollee premiums would be allowed to increase to amounts necessary to produce premium income equal to 25 percent of program costs for elderly enrollees. The limitation would again apply with respect to periods beginning July 1, 1985 and thereafter.

The "Social Security Amendments of 1983" (Public Law 98-21) postponed the scheduled July 1, 1983 increase to January 1, 1984 to coincide with the delay in the cost-of-living increase in social security cash benefit payments. Future increases will occur in January of each year based on calculations made the previous September. Public Law 98-21 further provided that the suspension of limitations as authorized by TEFRA is to apply for the two-year period beginning January 1, 1984.

Committee amendment.—The amendment makes permanent the existing temporary provision which fixes the proportion of the Part B Medicare costs financed by enrollees at 25 percent of program costs.

Effective date.—January 1, 1984.

Estimated savings.—

Fiscal years:	*Millions*
1984	0
1985	0
1986	$359
3-year total	359

LIMITATION ON PHYSICIAN FEE PREVAILING CHARGE LEVEL

(Section 202 of the bill)

Present law.—Under current law, medicare pays for physician services on the basis of Medicare-determined "reasonable charges." "Reasonable charges" are the lesser of: a physician's actual charges, the customary charges made by an individual physician for specific services, or the prevailing level of charges made by

other physicians for specific services in a geographic area. The amounts recognized by Medicare as customary and prevailing charges are updated annually (on July 1) to reflect changes in physician charging practices. Increases in prevailing charge levels are limited by an economic index which reflects changes in the operating expenses of physicians and in general earnings levels. The economic index limit promulgated for the period July 1, 1983 through June 30, 1984 represents an increase of 5.85 percent over the index utilized for the previous 12-month period.

Committee amendment.—The amendment provides that the prevailing charge level which was in effect prior to the annual updating which occurred on July 1, 1983 would be utilized for the October 1, 1983–June 30, 1984 period. Thus, for this nine month period until July 1, 1984, prevailing limits for all physician services would revert to the levels applicable during the July 1, 1982–June 30, 1983 fee screen year. Physicans' current customary charge screens would not be affected by the rollback.

Effective date.—October 1, 1983.

Estimated savings.—

Fiscal years:	*Millions*
1984	$309
1985	453
1986	521
3-year total	1,283

MEDICAID COVERAGE FOR PREGNANT WOMEN

(Section 203 of the bill)

Present law.—Prior to the enactment of the "Omnibus Budget Reconciliation Act of 1981" (Public Law 97–35) States were permitted to make AFDC payments to pregnant women on the basis of their unborn children. Pregnant women who are entitled to AFDC cash payments on this basis were also entitled to Medicaid coverage. Public Law 97–35 prohibited States from making AFDC cash payments to a pregnant woman on the basis of her unborn child until the sixth month of pregnancy. However, States are permitted to extend Medicaid eligibility to these women from the time the pregnancy has been medically verified. An estimated 80 percent of the States and jurisdictions have elected to provide coverage to a pregnant woman on the basis of her unborn child for either all or a portion of her pregnancy.

Committee amendment.—The amendment would mandate States, for a two-year period beginning August 1, 1983, to provide Medicaid coverage beginning with the medical determination of pregnancy to every woman who would be eligible for AFDC if the child were born.

Effective date.—August 1, 1983. A later implementation date is permitted where State legislation is required.

Estimated costs.—

Fiscal years:	*Millions*
1984	$25
1985	25

1986	0
3-year total	50

ELIMINATION OF PART B DEDUCTIBLE FOR CERTAIN DIAGNOSTIC LABORATORY TESTS

(Section 204 of the bill)

Present law.—Present law authorizes the Secretary to negotiate with a laboratory a payment rate that is considered the full charge for diagnostic tests. The payment, which is made directly to the laboratory, equals 100 percent of the negotiated rate subject to the annual Part B deductible. The beneficiary is not liable for coinsurance payments.

Committee amendment.—The amendment eliminates application of the annual part B deductible in the case of diagnostic tests performed in a laboratory which has entered into a negotiated rate agreement with the Secretary. This would provide an incentive for laboratories to enter into such agreements and thereby reduce costs associated with individual billing of Medicare beneficiaries.

Effective date.—Enactment.

Estimated savings.—N.A.

PAYMENT FOR SERVICES FOLLOWING TERMINATION OF PARTICIPATION AGREEMENTS WITH HOME HEALTH AGENCIES AND HOSPICES

(Section 205 of the bill)

Present law.—Under current law, if Medicare participation of a home health agency or a hospice is terminated, the Secretary is required to continue to pay for services provided to a beneficiary until the end of the calendar year in which the termination took place. This requirement is only applicable to services provided under an individual plan of care established prior to the termination of the agency.

Committee amendment.—The amendment changes from the end of the calendar year to 30 days after termination, the ending of coverage for services provided under a plan established prior to the termination date of the participation agreement. This amendment brings provisions for home health agencies and hospices into conformity with provisions for hospitals and skilled nursing facilities.

Effective date.—Enactment.

Estimated savings.—N.A.

REPEAL OF SPECIAL TUBERCULOSIS TREATMENT REQUIREMENTS UNDER MEDICARE AND MEDICAID

(Section 206 of the bill)

Present law.—Present law contains a number of provisions intended to assure that institutional services provided to Medicare and Medicaid patients suffering from tuberculosis are not custodial in nature and that such treatment can reasonably be expected to improve the patient's condition or render the condition noncommunicable.

Committee amendment.—The amendment repeals the special provisions. Advances in the active treatment of tuberculosis make such safeguards against paying for custodial care for tuberculosis patients unnecessary. The amendment also eliminates the special provider category in present law for tuberculosis hospitals in the Medicare and Medicaid programs.

Effective date.—Enactment.

Estimated savings.—N.A.

MEDICARE RECOVERY AGAINST CERTAIN THIRD PARTIES

(Section 207 of the bill)

Present law.—Under current law, the Medicare program may make benefit payments for services for which other third party insurance programs (e.g., worker's compensation, auto or liability insurance, and employer health plans) are ultimately liable for some or all of the costs. However, the Secretary does not now have the right of subrogation to become a party to claims against other liable parties or to recover directly from such parties.

Committee amendment.—The amendment establishes the statutory right of Medicare to recover directly from a liable third party, if the beneficiary himself does not do so, and to pay a beneficiary, or on the beneficiary's behalf, pending recovery where such third party is not expected to pay promptly. The amendment would also permit the Secretary to recover directly from the third party whether or not the beneficiary brings suit to recover and subrogate to the United States the right of the individual or anyone else to payment from the third party. These provisions are intended to improve the ability of the Medicare program to obtain reimbursement to which it is entitled by law.

Effective date.—Enactment.

Estimated savings.—N.A.

INDIRECT PAYMENT OF SUPPLEMENTARY MEDICAL INSURANCE BENEFITS

(Section 208 of the bill)

Present law.—Current law does not, in general, permit payments to be made to anyone other than a beneficiary or an entity providing services.

Committee amendment.—The amendment permits Part B payments to be made to a health benefits plan whose payment is accepted by the physician or other supplier as payment in full.

Effective date.—Enactment.

Estimated savings.—N.A.

ELIMINATION OF HEALTH INSURANCE BENEFITS ADVISORY COUNCIL

(Section 209 of the bill)

Present law.—Section 1867 of the Social Security Act provides for a 19 member panel of health experts (the Health Benefits Advisory Council or HIBAC) appointed by the Secretary to advise on matters of general policy with respect to the Medicare program.

Committee amendment.—The amendment repeals Section 1867. HIBAC was very active in the early years of the medicare program when regulations were first promulgated. As the Federal Government gained experience in administering the Medicare program, the Council's advisory functions with respect to regulations became less important. With passage of the Social Security Amendments of 1972, Public Law 92-603, the Council's authority to review regulations and recommend changes was specifically deleted, and its role limited to advice on matters of "general policy." Also, its purview was extended to include the Medicaid program. However, HIBAC has not been called upon to advise the Secretary since late in 1976, and there are currently no members.

Effective date.—Enactment.

Estimated savings.—N.A.

HOSPITAL ACCREDITATION SURVEYS OF THE AMERICAN OSTEOPATHIC ASSOCIATION NOT TO BE DISCLOSED

(Section 210)

Present law.—Current law contains certain disclosure safeguards relating to survey information used by the Secretary in connection with the hospital certification process under Medicare. However, the law only specifically refers to surveys conducted by the Joint Commission on the Accreditation of Hospitals (JCAH).

Committee amendment.—The amendment extends the same disclosure protections given JCAH survey information to similar survey information provided to the Secretary by the American Osteopathic Association or other national accreditation organizations.

Effective date.—Enactment.

Estimated savings.—N.A.

FLEXIBLE SANCTIONS FOR NONCOMPLIANCE WITH REQUIREMENTS FOR END STAGE RENAL DISEASE FACILITIES

(Section 211 of the bill)

Present law.—Current law and regulations provide for decertification of end-stage renal disease (ESRD) facilities that are not in complete compliance with Medicare program requirements.

Committee amendment.—The amendment allows the Secretary to apply intermediate sanctions, such as a graduated reduction of reimbursement to ESRD facilities, when noncompliance does not jeopardize patient health or safety or justify decertification of such facilities. Noncompliance would, in these cases, deal primarily with administrative requirements. This amendment makes the treatment of ESRD facilities comparable to the treatment of nursing homes which are out of compliance.

Effective date.—Enactment.

Estimated savings.—N.A.

USE OF ADDITIONAL ACCREDITING ORGANIZATIONS UNDER MEDICARE

(Section 212 of the bill)

Present law.—Under current law, the Secretary has authority to rely on certain accrediting organizations in determining whether hospitals, skilled nursing facilities, home health agencies, ambulatory surgical centers and hospice programs meet Medicare requirements.

Committee amendment.—The amendment extends the Secretary's authority to permit him to rely on such organizations in determining whether rural health clinics, laboratories, clinics, rehabilitation agencies, including outpatient rehabilitation facilities, and public health agencies meet Medicare requirements (and clarify his authority with respect to ambulatory surgical centers). The standards of an accrediting organization chosen must be at least equivalent to those of the Secretary, and it must have a satisfactory record of application of such standards.

Effective date.—Enactment.

Estimated savings.—N.A.

REPEAL OF EXCLUSION OF FOR-PROFIT ORGANIZATIONS FROM RESEARCH AND DEMONSTRATION GRANTS

(Section 213 of the bill)

Present law.—Current law limits the awarding of grants (under sections 1110 of the Social Security Act and section 222(b) of the 1972 Medicare amendments) for the conduct of research and demonstrations to non-profit organizations. However, contracts are permitted to be awarded to both for-profit and not-for-profit organizations.

Committee amendment.—The amendment extends the research and demonstration grant authority to for-profit organizations as well as non-profit organizations.

Effective date.—Enactment.

Estimated savings.—N.A.

REQUIREMENTS FOR MEDICAL REVIEW AND INDEPENDENT PROFESSIONAL REVIEW UNDER MEDICAID

(Section 214 of the bill)

Present law.—Under current law, medical review requirements for skilled nursing facilities (SNFs) and independent professional review for intermediate care facilities (ICFs) under Medicaid both call for teams of physicians, registered nurses and other appropriate personnel to conduct virtually similar kinds of review.

Committee amendment.—The amendment makes consistent State plan requirements for medical review and independent professional review thereby clarifying that there is no substantial statutory difference between review of these organizations. The amendment also corrects a technical error in present law to assure that Christian Science sanatoria are excluded from the revised medical review/independent professional review requirements.

Effective date.—Enactment.

Estimated savings.—N.A.

FLEXIBILITY IN SETTING PAYMENT RATES FOR HOSPITALS FURNISHING LONG-TERM CARE SERVICES UNDER MEDICAID

(Section 215 of the bill)

Present law.—Current law contains special requirements for the establishment of payment rates for hospitals furnishing skilled nursing or intermediate care facility services under Medicaid.

Committee amendment.—The amendment deletes the specific requirements for setting payment rates applicable only to hospital furnished long-term care services. Under the amendment such rates must meet the same general criteria as are applicable to rates for similar services provided by long-term care institutions to Medicaid recipients.

Effective date.—Enactment.

Estimated savings.—N.A.

AUTHORITY OF SECRETARY TO ISSUE AND ENFORCE SUBPOENAS UNDER MEDICAID

(Section 216 of the bill)

Present law.—Current law authorizes the Secretary to issue and seek enforcement of subpoenas under Medicare to obtain information needed in connection with hearings, investigations and other matters related to program fraud and abuse.

Committee amendment.—The amendment authorizes the Secretary to issue and seek enforcement of subpoenas under Medicaid to the same extent that he has authority under the Medicare program.

Effective date.—Enactment.

Estimated savings.—N.A.

REPEAL OF AUTHORITY FOR PAYMENTS TO PROMOTE CLOSING AND CONVERSION OF UNDERUTILIZED HOSPITALS

(Section 217 of the bill)

Present law.—Section 2101 of the "Omnibus Budget Reconciliation Act of 1981" (Public Law 97-35) authorized the Secretary to make Medicare and Medicaid payments to cover capital and increased operating costs associated with the conversion or closing of underutilized hospital facilities. The provision, which has never been implemented, restricts the number of facilities which may receive these funds to no more than 50 prior to January 1, 1984.

Committee amendment.—The amendment repeals this provision.

Effective date.—Enactment.

Estimated savings.—N.A.

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PRESIDENTIAL APPOINTMENT OF AND PAY LEVEL FOR THE ADMINISTRATOR OF THE HEALTH CARE FINANCING ADMINISTRATION

(Section 218 of the bill)

Present law.—By law, the Administrator of the Health Care Financing Administration (HCFA) is in the Senior Executive Service and is appointed by the Secretary of the Department of Health and Human Services.

Committee amendment.—The amendment provides for the appointment of the Administrator of HCFA by the President, with the advice and consent of the Senate. The position and pay of the Administrator is increased to Level IV of the Executive Schedule.

Effective date.—Applies to appointments to the position made after enactment.

Estimated savings.—N.A.

EXCLUSION OF CERTAIN ENTITIES OWNED OR CONTROLLED BY INDIVIDUALS CONVICTED OF MEDICARE OR MEDICAID RELATED CRIMES

(Section 219 of the bill)

Present law.—Current law authorizes the Secretary to bar from participation in Medicare (and to direct State agencies to bar from Medicaid) providers in which a significant interest is held by a person convicted of program-related criminal offenses.

Committee amendment.—The amendment extends the Secretary's authority to also exclude from Medicare participation (and to direct State agencies to exclude from Medicaid participation) any entity or supplier of services in which a significant ownership or controlling interest is held by a person convicted of program related criminal offenses.

Effective date.—Enactment.

Estimated savings.—N.A.

JUDICIAL REVIEW OF PROVIDER REIMBURSEMENT REVIEW BOARD DECISIONS

(Section 220 of the bill)

Present law.—The "Social Security Amendments of 1983" (Public Law 98–21) permits groups of providers to bring action in the judicial district in which the largest number of them are located. Under prior law, group judicial appeals could only be made in the District of Columbia. Public Law 98–21 also requires certain appeals by providers which are under common ownership or control to be made as a group.

These provisions were included in a section of Public Law 98–21 entitled "Conforming Amendments" and were not assigned a specific effective date. Therefore, this change together with most of the prospective payment provisions will "apply to items and services furnished by . . . a hospital beginning with its first cost reporting period that begins on or after October 1, 1983."

Committee amendment.—The amendment clarifies the effective date of the judicial review provisions.

Effective date.—Applies to court actions brought on and after the enactment of Public Law 98–21.
Estimated savings.—N.A.

ACCESS TO HOME HEALTH SERVICES

(Section 221 of the bill)

(a) Present law.—Current law requires a physician to certify to a patient's health needs and establish a plan for his care before the patient can qualify for home health benefits. The Secretary is directed, however, to prescribe regulations to disqualify physicians from carrying out these functions for patients of any agency in which they have a significant ownership interest or a significant financial or contractual relationship.
Committee amendment.—The amendment permits a physician who has a financial interest in an agency which is a sole community provider to carry out the certification and plan-of-care functions for patients who will receive services from the agency. Existing regulations, which were intended to prevent potential conflicts of interest, have created a serious problem for the relatively few patients whose physicians have an interest in the only agency in the area. These patients have been unable to qualify for home health benefits unless they switched physicians.
Effective date.—Enactment.
Estimated savings.—N.A.

(b) Present law.—Current regulations specifying which physicians are disqualified from carrying out the certification and plan-of-care functions for the patients of a home health agency include physicians who are uncompensated officers or directors of incorporated agencies even though they have no financial interest in its operation.
Committee amendment.—The amendment deletes from the list of disqualified physicians uncompensated officers or directors of incorporated agencies. These physicians do not stand to gain or lose from referrals to the agency.
Effective date.—Enactment.
Estimated savings.—N.A.

MEDICARE HOSPICE AMENDMENT

(Section 222 of the bill)

Present law.—By law, Medicare reimbursement for hospice care will be subject to an area adjusted limit or cap set at 40 percent of the average medicare per capita expenditure during the last six months of life for medicare beneficiaries dying of cancer. Under this provision, the cap amount is estimated to be about $4,200 for the first year of the program.
Committee amendment.—The amendment sets the per capita amount for the first year at $6,500 instead of equating it to 40 percent of the cost of care during the last six months of life for cancer patients. This amount would be updated annually based on the medical expenditure category of the consumer price index for all

urban consumers (U.S. city average) published by the Bureau of Labor Statistics.

Effective date.—Applies to hospice care provided on or after November 1, 1983 (the beginning date of the hospice benefit).

Estimated savings.—N.A.

PUBLICATION OF PHYSICIAN ASSIGNMENT LIST

(Section 223 of the bill)

Present law.—Payment for physicians' services under Medicare is made by the part B carrier either to the doctor or to the beneficiary dependent upon whether or not the physician has accepted assignment for the claim. In the case of nonassigned claims, payment is made directly to the beneficiary on the basis of an itemized bill, paid or unpaid. The beneficiary is responsible for the deductible and coinsurance amounts plus any difference between the physician's actual charge and the Medicare-determined reasonable charge. Alternatively, the beneficiary may assign (i.e., transfer) his rights to payment to the physician provided the physician is willing to accept Medicare's reasonable charge determination as the full charge for covered services. If the physician accepts assignment, he bills the program directly and is paid Medicare's charge less any deductible and the coinsurance. He may not charge the beneficiary (nor can he collect from another party such as a private insurer) more than the applicable deductible and coinsurance amounts.

A physician may accept or refuse requests for assignments on a bill-by-bill basis, from different patients at different times, or from the same patient at different times. However, he is precluded from "fragmenting" bills for the purpose of circumventing reasonable charge limitations; he must either accept assignment or bill the patient for all of the services performed on one occasion.

When a physician accepts assignment, the beneficiary is protected against having to pay any difference between Medicare's determined reasonable charge and the physician's actual charge. Further, the patient never has to handle the paperwork in connection with the claim. Only about half of Medicare's claims are paid on an assignment basis. In the remaining cases, the beneficiary is liable for any difference between the actual charge and the Medicare determined reasonable charge—an amount that can sometimes pose a financial burden.

Under current law, there is no established mechanism to provide Medicare beneficiaries with information as to whether or not a physician accepts assignment.

Committee amendment.—The committee amendment requires the Secretary to annually prepare lists containing the complete names and addresses, assignments ratios and volume of services of each physician. It is the explicit intent of this Committee to give the Secretary flexibility to determine thresholds, if any, for inclusion of physicians in the list. For example, the Secretary may determine to publish lists of physicians who accept assignment for at least 25 percent of claims. The Committee believes that the Secretary should have flexibility, if appropriate, to exclude from the list,

those physicians who infrequently perform services for Medicare beneficiaries (e.g., less than 50 or 100 services per year).

Such lists shall be prepared at least for each carrier jurisdiction, and, if practical, for smaller geographic areas such as cities, counties or ZIP-codes. Carriers should organize the lists in a manner to be of most value to beneficiaries. For example, lists could be organized by specialty of physician and alphabetically within each specialty. In addition, where physicians practice in groups, carriers should indicate the names of all physicians within a group or, if not available, annotate the list in such a way that users of the list can find the group name and recognize that the statistics are group statistics.

Copies of the listing shall be made available in the Social Security District Offices and other locations as the Secretary determines to be appropriate. Copies should be made available to senior citizen organizations and may be made available to local media.

Effective date.—Calendar years beginning after date of enactment.

III. Regulatory Impact of the Bill

Pursuant to paragraph 11(b) of Rule XXVI of the Standing Rules of the Senate, the committee makes the following statement concerning the regulatory impact that might be incurred in carrying out the provisions of this bill.

A. NUMBERS OF INDIVIDUALS AND BUSINESSES WHO WOULD BE REGULATED

The bill does not involve new or expanded regulations involving individuals. However, the provisions requiring employers to provide open enrollment opportunities to employees will have an effect on businesses. Because of the number of employers who already offer an open enrollment opportunity and because small employers are exempted it is not possible for the Committee to accurately estimate the total number affected, although we believe it to be less than one third of all employers. However, this one third of all employers represents approximately three quarters of all employees.

B. ECONOMIC IMPACT ON INDIVIDUALS, CONSUMERS, AND BUSINESSES

The increase in costs to employers as a result of this new mandate is expected to be quite small as a percentage of total dollars committed to employee health benefits.

C. IMPACT ON PERSONAL PRIVACY

This bill does not relate to the personal privacy of individual taxpayers except to the extent that they notify the federal government of the failure of their employer to comply with the mandate for an open enrollment.

D. DETERMINATION OF THE AMOUNT OF PAPERWORK

The bill will increase paperwork for the offices determining eligibility for unemployment compensation and for the State agency designated to administer the benefits portion of the bill. The bill would also provide for limited additional paperwork for those employers not currently offering an open enrollment opportunity.

IV. BUDGETARY IMPACT OF THE BILL

U.S. CONGRESS,
CONGRESSIONAL BUDGET OFFICE,
Washington, D.C., July 20, 1983.

Hon. ROBERT DOLE,
Chairman, Committee on Finance,
U.S. Senate, Washington, D.C.

DEAR MR. CHAIRMAN: Pursuant to Section 403 of the Congressional Budget Act of 1974, the Congressional Budget Office has prepared the attached cost estimate for S. 951, the Health Care for the Unemployed Act of 1983, as ordered reported by the Senate Committee on Finance, July 13, 1983.

Should the Committee so desire, we would be pleased to provide further details on this estimate.

Sincerely,

ALICE M. RIVLIN, *Director.*

CONGRESSIONAL BUDGET OFFICE COST ESTIMATE, JULY 20, 1983

1. Bill number: S. 951.
2. Bill title: Health Care for the Unemployed Act of 1983.
3. Bill status: As ordered reported by the Senate Committee on Finance, July 13, 1983.
4. Bill purpose: This bill would amend the Social Security Act to provide health care benefits for the unemployed and to make additional changes in federal health care programs, including Medicare and Medicaid.

This bill would amend Title XX of the Social Security Act, to provide health care for the unemployed and their immediate family members through a block grant. The bill would also place requirements on employers to meet certain conditions related to health insurance coverage for persons who lose employment.

Health care services would be available to jobless workers and their immediate family members. The bill would restrict eligibility in several ways. The bill covers only individuals and family members who are currently receiving or who have exhausted unemployment compensation. This bill would not cover those individuals who could obtain Medicaid or Medicare coverage, health coverage through an employed spouse, or coverage through a program for which a contribution was being made by an employer. Health coverage would not be provided to individuals who exceed a certain family income.

The bill would also amend the Medicare and Medicaid programs, Titles XVIII and XIX of the Social Security Act. Under Supplementary Medical Insurance, premiums would be permanently set at approximately 25 percent of program costs.

This bill would also limit increases in physician fees for 1984. The prevailing charge limits set under Part B in Medicare for July 1, 1982–June 30, 1983 would be in effect beginning October 1, 1983 through June 30, 1984.

The bill would amend the Medicaid program to mandate coverage of those pregnant women which the states may currently choose to cover. This amendment would expire on July 30, 1985.

BASIS OF ESTIMATE

The following detailed cost analysis addresses only those sections of this bill that would have a budgetary impact.

Health insurance for the unemployed

Estimated outlays assume full appropriation of authorization levels. The 1983 costs assume no expenditures for delivery of health services. However, monies are assumed to be used in 1983 for planning and development of state programs. This bill will reimburse states for expenses incurred in providing services to eligible individuals through January 31, 1986.

Medicare and Medicaid

The bill would also amend the Medicare and Medicaid programs. Premiums for the Supplementary Medical Insurance (SMI) program would be determined based on 50 percent of the monthly actuarial rate (MAR) for aged enrollees. This premium amount would be charged to both the aged and the disabled enrollees. As MARs for the aged represent one-half a month's cost per aged person under SMI, premiums under this legislation would be approximately 25 percent of program costs. Under current law, premiums are determined using this calculation. However, this is effective only through the end of calendar year 1985. After 1985, premiums would increase by the same cost-of-living adjustment used for increasing benefits under the Social Security program. Thus savings for this provision would not begin until January 1, 1986. Under current law premiums for calendar year 1986 are estimated to be $16.90 per month, and this legislation is estimated to raise premiums to $18.20 per month. The extra $1.30 per month in premiums that would be collected under this legislation for approximately 30.6 million enrollees would increase premiums by $359 for the last nine months in fiscal year 1986.

The bill would also limit increases in physician fees for 1984. The prevailing charge limits set under SMI for last year (July 1, 1982–June 30, 1983) would go back into effect beginning October 1, 1983 for nine months. On July 1, 1984, prevailing charge limits would increase, however, the increase could not compensate for the loss due to the temporary freeze. Thus savings would be realized in 1984 and each year thereafter as the prevailing charge would always be lower than it would have been if no freeze had been imposed.

Under current law, CBO estimates that physician fees for July 1, 1983 through June 30, 1984 would have increased by about 14.2 percent over the previous year. This figure represents estimated increases in prevailing and customary charges as well as increases in

utilization. The freeze on prevailing charge limits is estimated to hold the overall increase in physician fees to about 8.4 percent. This would only be in effect for the nine months beginning October 1, 1983.

Freezing physician fees would also lower premiums. This occurs because premiums would be based on percentage of program costs and freezing physician fees would lower program costs. Thus a share of the savings from freezing physician fees will result in lower premiums. In 1984 premiums without a physician fee freeze are estimated to be $14.30 per month and with a fee freeze premiums are estimated to be $14.10 a month. For the approximately 28.7 million recipients, premiums are estimated to decrease by about $53 million in 1984.

5. Estimated cost to the Federal Government:

[By fiscal year, in millions of dollars]

	1983	1984	1985	1986	1987	1988
Estimated authorization levels:						
Health care for the unemployed	900	900				
Budget authority:						
Modify part B premium				−359	−969	−1,701
Freeze physician fees		−405	−570	−655	−745	−845
Effect of fee freeze on part B premiums		53	99	111	141	154
Medicaid offsets		−2	−2	−2	−2	−2
Mandate medicaid coverage of pregnant women		25	25			
Total estimated authorization levels and budget authority	900	571	−448	−905	−1,575	−2,394
Estimated outlays:						
Health care for the unemployed	20	700	945	135		
Modify part B premium				−359	−969	−1,701
Freeze physician fees		−360	−550	−630	−720	−820
Effect of fee freeze on part B premiums		53	99	111	141	154
Medicaid offsets		−2	−2	−2	−2	−2
Mandate medicaid coverage of pregnant women		25	25			
Total	20	416	517	−745	−1,550	−2,369

The costs of this bill fall within budget function 550.

Medicaid offsets would result from the physician fee freeze and the change in SMI premiums. About 12-14 percent of Medicare recipients are also eligible for Medicaid. As premiums would increase under this legislation in 1986, the federal government would have to pay its share of this increase for dual Medicare-Medicaid eligibles. Alternatively, the savings from the physician fee freeze would result in a lower copayment amount, and save federal money in the Medicaid program.

The bill would also amend the Medicaid program to mandate coverage for certain pregnant women. Currently states may choose to cover single pregnant women who meet the need standards, but have no other children. This bill would mandate coverage for this group through July 30, 1985. About 20 states currently do not cover these women. Based on data from the March 1982 Current Population Survey, about 225,000 women in their child-bearing age live in the 20 affected states. Using fertility rates for low income individ-

uals, CBO estimates that this legislation would extend coverage to 15,000–20,000 pregnant women.

6. Estimated cost to state and local governments: This bill would require state matching for the costs of health care for the unemployed. State matching rates could vary from 50 percent to 95 percent depending on the state's insured unemployment rate. Because states have discretion in determining the extent of their participation in this program, it is difficult to estimate the costs to state and local governments. The estimate of state and local costs assumes that states with higher matching rates will be more likely to participate. Thus, the estimate is based on an average matching rate between 75 percent and 90 percent so that costs to the states would be between $70 million and $170 million in 1984, between $100 million and $230 million in 1985, and between $15 million and $35 million in 1986.

In addition, federal funds provided under this bill may defray current state expenditures for the health care of this population. However, we are unable to estimate this budget impact on state and local governments.

The Medicaid provisions in this bill would also result in a cost to state and local governments. Mandating coverage for pregnant women would cost the states about $20 million in 1984 and $20 million in 1985. The effect of the physician fee freeze and premium charge would lower state Medicaid costs by $1 million in each fiscal year from 1984 to 1988.

7. Estimate comparison: None.

8. Previous CBO estimate: None.

9. Estimate prepared by: Hinda Ripps Chaikind and Diane Burnside.

10. Estimate approved by: James L. Blum, Assistant Director for Budget Analysis.

V. Changes in Existing Law

In compliance with paragraph 12 of rule XXVI of the Standing Rules of the Senate, the changes in existing law made by the bill as reported are shown below (existing law proposed to be omitted is enclosed in black brackets, new matter is printed in italic, existing law in which no change is proposed is shown in roman):

Social Security Act

* * * * * * *

TITLE III—GRANTS TO STATES FOR UNEMPLOYMENT COMPENSATION

* * * * * * *

Provisions of State Laws

Sec. 303. (a) The Secretary of Labor shall make no certification for payment to any State unless it finds that the law of such State,

approved by the Secretary of Labor under the Federal Unemployment Tax Act, includes provision for—

* * * * * * *

(5) Expenditure of all money withdrawn from an unemployment fund of such State, in the payment of unemployment compensation, exclusive of expenss of administration, and for refunds of sums erroneously paid into such fund and refunds paid in accordance with the provisions of section 1606(b) of the Federal Unemployment Tax Act: Provided, That an amount equal to the amount of employee payments into the unemployment fund of a State may be used in the payment of cash benefits to individuals with respect to their disability, exclusive of expenses of administration: *Provided further,* That the amounts specified by section 903(c)(2) may, subject to the conditions prescribed in such section, be used for expenses incurred by the State for administration of its unemployment compensation law and public employment offices: Provided further, That nothing in this paragraph shall be construed to prohibit deducting an amount from unemployment compensation otherwise payable to an individual and using the amount so deducted to pay for health insurance *or health care* if the individual elected to have such deduction made and such deduction was made under a program approved by the Secretary of Labor *or a contribution amount under section 2008 of the Social Security Act*; and

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TITLE XI—GENERAL PROVISIONS AND PROFESSIONAL STANDARDS REVIEW

PART A—GENERAL PROVISIONS

* * * * * * *

COOPERATIVE RESEARCH OR DEMONSTRATION PROJECTS

SEC. 1110. (a)(1) There are hereby authorized to be appropriated for the fiscal year ending June 30, 1957, $5,000,000 and for each fiscal year thereafter such sums as the Congress may determine for (A) making grants to States and public and other [nonprofit] organizations and agencies for payment part of the cost of research or demonstration projects such as those relating to the prevention and reduction of dependency, or which will aid in effecting coordination of planning between private and public welfare agencies or which will help improve the administration and effectiveness of programs carried on or assisted under the Social Security Act and programs related thereto, and (B) making contracts or jointly financed cooperative arrangements with States and public and other organizations and agencies for the conduct of research or demonstration projects relating to such matters.

* * * * * * *

APPOINTMENT OF THE ADMINISTRATOR OF THE HEALTH CARE FINANCING ADMINISTRATION

SEC. 1117. The Administrator of the Health Care Financing Administration shall be appointed by the President by and with the advice and consent of the Senate.

EXCLUSION OF CERTAIN INDIVIDUALS CONVICTED OF MEDICARE- OR MEDICAID-RELATED CRIMES

SEC. 1128. (a) * * *

(b) Whenever the Secretary determines, with respect to an entity, that a person who has a direct or indirect ownership or control interest of 5 percent or more in the entity, or who is an officer, director, agent, or managing employee (as defined in section 1126(b)) of such entity, is a person described in section 1126(a), the Secretary—

(1) may bar from participation in the program under title XVIII, for such period as he may deem appropriate, each such entity otherwise eligible to participate in such program;

(2) shall promptly notify each appropriate State agency administering or supervising the administration of a State plan approved under title XIX of the fact and circumstances of the determination, and may require each such agency to bar the entity from participation in the program for such period as he may specify, which in the case of an entity specified in paragraph (1), may not exceed the period established pursuant to paragraph (1); and

(3) shall promptly notify the appropriate State or local agency or authority having responsibility for the licensing or certification of such entity of the fact and circumstances of such determination, request that appropriate investigations be made and sanctions invoked in accordance with applicable State law and policy, and request that such State or local agency or authority keep the Secretary and the Inspector General of the Department of Health and Human Services fully and currently informed with respect to any actions taken in response to such request.

[(b)] (c) Whenever the Secretary makes a final determination to impose a civil money penalty or assessment against a person (including an organization, agency, or other entity) under section 1128A relating to a claim under title XVIII or XIX, the Secretary—

(1) may bar the person from participation in the program under title XVIII, and

(2)(A) shall promptly notify each appropriate State agency administering or supervising the administration of a State plan approved under title XIX of the fact and circumstances of such determination, and (except as provided in subparagraph (B)) may require each such agency to bar the person from participation in the program established by such plan for such period as he shall specify, which in the case of an individual shall be the period established pursuant to paragraph (1), and

(B) may waive the requirement of subparagraph (A) to bar a person from participation in such program where he receives and approves a request for such waiver with respect to that person from the State agency referred to in that subparagraph.

[(c)] *(d)* A determination made by the Secretary under this section shall be effective at such time and upon such reasonable notice to the public and to the person furnishing the services involved as may be specified in regulations. Such determination shall be effective with respect to services furnished to an individual on or after the effective date of such determination (except that in the case of inpatient hospital services, post-hospital extended care services, and home health services furnished under title XVIII, determination shall be effective in the manner provided in paragraphs (3) and (4) of section 1866(b) with respect to terminations of agreements), and shall remain in effect until the Secretary finds and gives reasonable notice to the public that the basis for such determination has been removed and that there is reasonable assurance that it will not recur.

[(d)] *(e)* Any person *or entity* who is the subject of an adverse determination made by the Secretary under subsection [(a) or (b)] *(a), (b), or (c)* shall be entitled to reasonable notice and opportunity for a hearing thereon by the Secretary to the same extent as is provided in section 205(b), and to judicial review of the Secretary's final decision after such hearing as is provided in section 205(g).

TITLE XVIII—HEALTH INSURANCE FOR THE AGED AND DISABLED

* * * * * * *

PART A—HOSPITAL INSURANCE BENEFITS FOR THE AGED AND DISABLED

* * * * * * *

CONDITIONS OF AND LIMITATIONS ON PAYMENT FOR SERVICES

Requirement of Requests and Certifications

SEC. 1814. (a) Except as provided in subsections (d) and (g) and in section 1876, payment for services furnished an individual may be made only to providers of services which are eligible therefor under section 1866 and only if—

* * * * * * *

(2) physician certifies (and recertifies, where such services are furnished over a period of time, in such cases, with such frequency, and accompanied by such supporting material, appropriate to the case involved, as may be provided by regulations, except that the first of such recertifications shall be required in each case of inpatient hospital services not later than the 20th day of such period) that—

(A) in the case of inpatient psychiatric hospital services, such services are or were required to be given on an inpatient basis, by or under the supervision of a physician, for the psychiatric treatment of an individual; and (i) such treatment can or could reasonably be expected to improve the condition for which such treatment is or was necessary or (ii) inpatient diagnostic study is or was medically re-

quired and such services are or were necessary for such purposes;

[(B) in the case of inpatient tuberculosis hospital services, such services are or were required to be given on an inpatient basis, by or under the supervision of a physician, for the treatment of an individual for tuberculosis; and such treatment can or could reasonably be expected to (i) improve the condition for which such treatment is or was necessary or (ii) render the condition noncommunicable;]

* * * * * * *

(3) with respect to inpatient hospital services (other than inpatient psychiatric hospital services [and inpatient tuberculosis hospital services] which are furnished over a period of time, a physician certifies that such services are required to be given on an inpatient basis for such individual's medical treatment, or that inpatient diagnostic study is medically required and such services are necessary for such purpose, except that (A) such certification shall be furnished only in such cases, with such frequency, and accompanied by such supporting material, appropriate to the cases involved, as may be provided by regulations, and (B) the first such certification required in accordance with clause (A) shall be furnished no later than the 20th day of such period;

* * * * * * *

[(5) in the case of inpatient tuberculosis hospital services, the services are those which the records of the hospital indicate were furnished to the individual during periods when he was receiving treatment which could reasonably be expected to (A) improve his condition or (B) render it noncommunicable;]

* * * * * * *

To the extent provided by regulations, the certification and recertification requirements of paragraph (2) shall be deemed satisfied where, at a later date, a physician makes certification of the kind provided in subparagraph (A), [(B),] (C), (D), or (E) of paragraph (2) (whichever would have applied), but only where such certification is accompanied by such medical and other evidence as may be required by such regulations. With respect to the physician certification required by paragraph (2) for home health services furnished to any individual by a home health agency (other than an agency which is a governmental entity) and with respect to the establishment and review of a plan for such services, the Secretary shall prescribe regulations which shall become effective no later than July 1, 1981, and which prohibit a physician who has a significant ownership interest in, or a significant financial or contractual relationship with, such home health agency from performing such certification and from establishing or reviewing such plan. *For purposes of the preceding sentence, service by a physician as an uncompensated officer or director of a home health agency shall not constitute having a significant ownership interest in, or a significant financial or contractual relationship with, such agency. Such regulations shall not prohibit a physician who has a significant interest in, or a significant relationship with, an agency that is the only*

home health agency in a community from performing such certification and establishing or reviewing such plan with respect to individuals who are furnished, or to be furnished, services by such agency.

* * * * * * *

Payment for Hospice Care

(i)(1) Subject to the limitation under paragraph (2) and the provisions of section 1813(a)(4), the amount paid to a hospice program with respect to hospice care for which payment may be made under this part shall be an amount equal to the costs which are reasonable and related to the cost of providing hospice care or which are based on such other tests of reasonableness as the Secretary may prescribe in regulations (including those authorized under section 1861(v)(1)(A)), except that no payment may be for bereavement counseling and no reimbursement may be made for other counseling services (including nutritional and dietary counseling) as separate services.

(2)(A) The amount of payment made under this part for hospice care provided by (or under arrangements made by) a hospice program [located in a region (as defined by the Secretary)] for an accounting year may not exceed the "cap amount" [for the region] for the year (computed under subparagraph (B)) multiplied by the number of medicare beneficiaries in the hospice program in that year (determined under subparagraph (C)).

[(B) For purposes of subparagraph (A), the "cap amount" for a region for a year is computed as follows:

[(i) The Secretary, using records of the program under this title, shall identify individuals (or a representative sample of such individuals)—

[(I) who died during the base period (as defined in clause (v)),

[(II) with respect to whom the primary cause of death was cancer, and

[(III) who, during the six-month period preceding death, were provided benefits under this title.

[(ii) The Secretary shall determine a national average medicare per capita expenditure amount by (I) determining (or estimating) the amount of payments made under this title with respect to services provided to individuals identified in clause (i) during the six months before death, and (II) dividing such amount of payments by the number of such individuals.

[(iii) The Secretary, using the best available data, shall then compute a regional average medicare per capita expenditure amount for each region, but adjusting the national average medicare per capita expenditure amount (computed under clause (ii)) to reflect the relative difference between that region's average cost of delivering health care and the national average cost of delivering health care.

[(iv) The "cap amount" for a region for an accounting year is 40 percent of the regional average determined under clause (iii) for that region, increased or decreased by the same percentage as the percentage increase or decrease, respectively, in

the medical care expenditure category of the consumer price index for all urban consumers (U.S. city average), published by the Bureau of Labor Statistics, from the fourth month of the base period to the fifth month of the accounting year.

[(v) For purposes of this subparagraph, the term "base period" means the most recent period of 12 months (ending before the date proposed regulations are first issued to carry out this paragraph) for which the Secretary determines he has sufficient data to make the determinations required under clauses (i) through (iii).]

(B) For purposes of subparagraph (A), the "cap amount" for a year is $6,500, increased or decreased, for accounting years that end after October 31, 1984, by the same percentage as the percentage increase or decrease, as the case may be, in the medical care expenditure category of the Consumer Price Index for all urban consumers (United States city average), published by the Bureau of Labor Statistics, from March 1984 to the fifth month of the accounting year.

* * * * * * *

PART B—SUPPLEMENTARY MEDICAL INSURANCE BENEFITS FOR THE AGED AND DISABLED

PAYMENT OF BENEFITS

SEC. 1833. (a) Except as provided in section 1876, and subject to the succeeding provisions of this section, there shall be paid from the Federal Supplementary Medical Insurance Trust Fund, in the case of each individual who is covered under the insurance program established by this part and incurs expenses for services with respect to which benefits are payable under this part, amounts equal to—

* * * * * * *

(b) Before applying subsection (a) with respect to expenses incurred by an individual during any calendar year, the total amount of the expenses incurred by such individual during such year (which would, except for this subsection, constitute incurred expenses from which benefits payable under subsection (a) are determinable) shall be reduced by a deductible of $75; except that (1) such total amount shall not include expenses incurred for items and services described in section 1861(s) (10), (2) such deductible shall not apply with respect to home health services, [and] (3) such total amount shall not include expenses incurred for services the amount of payment for which is determined under subsection (a)(1)(G) or under subsection (i)(2) or (i)(4), *and (4) such deductible shall not apply with respect to diagnostic tests performed in a laboratory for which the Secretary has established a payment rate under subsection (h).* The total amount of the expenses incurred by an individual as determined under the preceding sentence shall, after the reduction specified in such sentence, be further reduced by an amount equal to the expenses incurred for the first three pints of which blood (or equivalent quantities of packed red blood cells, as defined under regulations) furnished to the individual during the calendar year, expect that such deductible for such blood shall in

accordance with regulations be appropriately reduced to the extent that there has been a replacement of such blood (or equivalent quantities of packed red blood cells, as so defined); and for such purposes blood (or equivalent quantities of packed red blood cells, as so defined) furnished such individual shall be deemed replaced when the institution or other person furnishing such blood (or such equivalent quantities of packed red blood cells, as so defined) is given one pint of blood for each pint of blood (or equivalent quantities of packed red blood cells, as so defined) furnished such individuals with respect to which a deduction is made under this sentence.

* * * * * * *

(h) With respect to diagnostic tests performed in a laboratory for which payment is made under this part to the laboratory, the Secretary is authorized to establish a payment rate which is acceptable to the laboratory and which would be considered the full charge for such tests. Such negotiated rate shall be limited to an amount not in excess of the total payment that would have been made for the services in the absence of such a rate *(including any deductible which would have been made under subsection (b)).*

* * * * * * *

PROCEDURE FOR PAYMENT OF CLAIMS OF PROVIDERS OF SERVICES

SEC. 1835. (a) Except as provided in subsections (b), (c), and (e), payment for services described in section 1832(a)(2) furnished an individual may be made only to providers of services which are eligible therefor under section 1866(a), and only if—

* * * * * * *

To the extent provided by regulations the certifiation and recertification requirement of paragraph (2) shall be deemed satisfied where at a later date, a physican makes a certification of the kind provided in subparagraph (A) or (B) of paragraph (2) (whichever would have applied), but only where such certification is accompanied by such medical and other evidence as may be required by such regulations. For purposes of this section, the term "provider of services" shall include a clinic, rehabilitation agency, or public health agency if, in the case of a clinic or rehabilitation agency, such clinic or agency meets the requirements of section 1861(p) (4) (A), or if, in the case of a public health agency, such agency meets the requirements of section 1861 (p)(4)(B), but only with respect to the furnishing of outpatient physical therapy services (as therein defined). With respect to the physician certification required by paragraph (2) for home health services furnished to any individual by a home health agency (other than an agency which is a governmental entity) and with respect to the establishment and review of a plan for such services, the Secretary shall prescribe regulations which shall be come effective no late than July 1, 1981, and which prohibit a physician who has a significant ownership interest in or a significant financial or contractural relationship with such home health agency from performing such certification and from establishing or reviewing such plan. *For purposes of the preceding sentence, service by a physician as an uncompensated officer or director*

of a home health agency shall not constitute have a significant ownership interest in, or a significant financial or contractual relationship with, such agency. Such regulations shall not prohibit a physician who has a significant interest in, or a significant relationship with, an agency that is the only home health agency in a community from performing such certification and establishing or reviewing such plan with respect to individuals who are furnished, or to be furnished, services by such agency.

AMOUNTS OF PREMIUMS

SEC. 1839. (a)(1) The Secretary shall, during September of 1983 and of each year thereafter, determine the monthly actuarial rate for enrollees age 65 and over which shall be applicable for the succeeding calendar year. Such actuarial rate shall be the amount the Secretary estimates to be necessary so that the aggregate amount for such calendar year with respect to those enrollees age 65 and over will equal one-half of the total of the benefits and administrative costs which he estimates will be payable from the Federal Supplementary Medical Insurance Trust Fund for services performed and related administrative costs incurred in such calendar year with respect to such enrollees. In calculating the monthly actuarial rate, the Secretary shall include an appropriate amount for a contingency margin.

[(2) The monthly premium of each individual enrolled under this part for each month after December 1983 shall, except as provided in subsections (b) and (e), be the amount determined under paragraph (3).

[(3) The Secretary shall, during September of 1983 and of each year thereafter, determine and promulgate the monthly premium applicable for individuals enrolled under this part for the succeeding calendar year. The monthly premium shall (except as otherwise provided in subsection (e)) be equal to the smaller of—

[(A) the monthly actuarial rate for enrollees age 65 and over, determined according to paragraph (1) of this subsection, for that calendar year, or

[(B) the monthly premium rate most recently promulgated by the Secretary under this paragraph, increased by a percentage determined as follows: The Secretary shall ascertain the primary insurance amount computed under section 215(a)(1), based upon average indexed monthly earnings of $900, that applied to individuals who became eligible for and entitled to old-age insurance benefits on November 1 of the year before the year of the promulgation. He shall increase the monthly premium rate by the same percentage by which that primary insurance amount is increased when, by reason of the law in effect at the time the promulgation is made, it is so computed to apply to those individuals for the following November 1.

[Whenever the Secretary promulgates the dollar amount which shall be applicable as the monthly premium for any period, he shall, at the time such promulgation is announced, issue a public statement setting forth the actuarial assumptions and bases employed by him in arriving at the amount of an adequate actuarial

rate for enrollees age 65 and over as provided in paragraph (1) and the derivation of the dollar amounts specified in this paragraph.]

(2) The monthly premium for each individual enrolled under this part for each month after December 1983 shall, except as provided in subsection (b), be an amount equal to 50 percent of the monthly actuarial rate for enrollees age 65 and over, as determined under paragraph (1) and applicable to such month.

(3) The Secretary shall, during September of 1983 and of each year thereafter, determine and promulgate the monthly premium applicable for individuals enrolled under this part for the succeeding calendar year. Whenever the Secretary promulgates the dollar amount which shall be applicable as the monthly premium for any period, he shall, at the time such promulgation is announced, issue a public statement setting forth the actuarial assumptions and bases employed by him in arriving at the amount of an adequate actuarial rate for enrollees age 65 and older as provided in paragraph (1) and the derivation of the dollar amounts specified in this paragraph.

(4) The Secretary shall also, during September of 1983 and of each year thereafter, determine the monthly actuarial rate for disabled enrollees under age 65 which shall be applicable for the succeeding calendar year. Such actuarial rate shall be the amount the Secretry estimates to be necessary so that the aggregate amount for such calendar year with respect to disabled enrollees under age 65 will equal one-half of the total of the benefits and administrative costs which he estimates will be payable from the Federal Supplementary Medical Insurance Trust Fund for services performed and related administrative costs incurred in such calendar year with respect to such enrollees. In calculating the monthly actuarial rate under this paragraph, the Secretary shall include an appropriate amount for a contingency margin.

(b) In the case of an individual whose coverage period began pursuant to an enrollment after his initial enrollment period (determined pursuant to subsection (c) or (d) of section 1837), the monthly premium determined under subsection (a) [or (e)]; shall be increased by 10 percent of the monthly premium so determined for each full 12 months (in the same continuous period of eligibility) in which he could have been but was not enrolled. For purposes of the preceding sentence, there shall be taken into account (1) the months which elapsed between the close of his initial enrollment period and the close of the enrollment period in which he enrolled, plus (in the case of an individual who reenrolls) (2) the months which elapsed between the date of termination of a previous coverage period and the close of the enrollment period in which he reenrolled. Any increase in an individual's monthly premium under the first sentence of this subsection with respect to a particular continuous period of eligibility shall not be applicable with respect to any other continuous period of eligibility which such individual may have.

(c) If any monthly premium determined under the foregoing provisions of this section is not a multiple of 10 cents, such premium shall be rounded to the nearest multiple of 10 cents.

(d) For purposes of subsection (b) (and section 1837(g)(1)), an individual's "continuous period of eligibility" is the period beginning with the first day on which he is eligible to enroll under section

1836 and ending with his death; except that any period during all of which an individual satisfied paragraph (1) of section 1836 and which terminated in or before the month preceding the month in which he attained age 65 shall be a separate "continuous period of eligibility" with respect to such individual (and each such period which terminates shall be deemed not to have existed for purposes of subsequently applying this section).

[(e)(1) Notwithstanding the provisions of subsection (a), the monthly premium for each individual enrolled under this part for each month after December 1983 and prior to January 1986 shall be an amount equal to 50 percent of the monthly actuarial rate for enrollees age 65 and over, as determined under subsection (a)(1) and applicable to such month.

[(2) Any increases in premium amounts taking effect prior to January 1986 by reason of paragraph (1) shall be taken into acount for purposes of determining increases thereafter under subsection (a)(3).]

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USE OF CARRIERS FOR ADMINISTRATION OF BENEFITS

SEC. 1842(a) * * *

(b)(1) Contracts with carriers under subsection (a) may be entered into without regard to section 3709 of the Revised Statutes or any other provision of law requiring competitive bidding.

* * * * * * *

(4)(A) In determining the prevailing charge levels under the third and fourth sentences of paragraph (3) for physicians' services, the Secretary shall not set any level higher than the same level as was set for the period ending June 30, 1983, in the case of that portion of the period ending June 30, 1984, which occurs after September 30, 1983.

(B) In determining the prevailing charge levels under the third and fourth sentences of paragraph (3) for physicians' services for periods beginning after June 30, 1984, the Secretary shall treat the levels as set under subparagraph (A) as having fully provided for economic changes which would have been taken into account but for the limitations contained in subparagraph (A).

[(4)] *(5)* Each contract under this section shall be for a term of at least one year, and may be made automatically renewable from term to term in the absense of notice by either party of intention to terminate at the end of the current term; except that the Secretary may terminate any such contract at anytime (after such reasonable notice and opportunity for hearing to the carrier involved as he may provide in regulations) if he finds that the carrier has failed substantially to carry out the contract or is carrying out the contract in a manner inconsistent with the efficient and effective administration of the insurance program established by this part.

[(5)] *(6)* No payment under this part for a service provided to any individual shall (except as provided in section 1870) be made to anyone other than such individual or (pursuant to an assignment described in subparagraph (B)(ii) of paragraph (3)) the physician or

other person who provided the service, except that payment may be made (A) to the employer of such physician or other person if such physician or other person is required as a condition of his employment to turn over his fee for such service to his employer, or (B) (where the service was provided in a hospital, clinic, or other facility) to the facility in which the service was provided if there is a contractual arrangement between such physician or other person and such facility under which such facility submits the bill for such service, *or (C) to an entity (i) which provides coverage of the service under a health benefits plan (to the extent that payment is not made under this part), (ii) which has paid the person who provided the service an amount which includes the amount payable under this part and which that person has accepted as payment in full for such service, and (iii) to which the individual has agreed in writing that payment may be made under this part.* No payment which under the preceding sentence may be made directly to the physician or other person providing the service involved (pursuant to an assignment described in subparagraph (B)(ii) of paragraph (3)) shall be made to anyone else under a reassignment or power of attorney (except to an employer or facility as described in clause (A) or (B) of such sentence); but nothing in this subsection shall be construed [(i)] *(I)* to prevent the making of such a payment in accordance with an assignment from the individual to whom the service was provided or a reassignment from the physician or other person providing such service if such assignment or reassignment is made to a governmental agency or entity or is established by or pursuant to the order of a court of competent jurisdiction, or [(ii)] *(II)* to preclude an agent of the physician or other person providing the service from receiving any such payment if (but only if) such agent does so pursuant to an agency agreement under which the compensation to be paid to the agent for his services for or in connection with the billing or collection of payments due such physician or other person under this title is unrelated (directly or indirectly) to the amount of such payments or the billings therefor, and is not dependent upon the actual collection of any such payment.

[(6)] *(7)*(A) In the case of physicians' services furnished to a patient in a hospital with a teaching program approved as specified in section 1861(b)(6) but which does not meet the conditions described in section 1861(b)(7), the carrier shall not provide (except on the basis described in subparagraph (C)) for payment for such services under this part—

(8)(A) Each year, the Secretary shall prepare a list containing the name, address, volume of services, and percent of the bills submitted for payment by each physician during the preceding calendar year that were paid on the basis of an assignment described in paragraph (3)(B)(ii) of paragraph (3). The Secretary may limit such list to those physicians who accepted such an assignment in a certain percentage of such physician's billings, as the Secretary may determine to be appropriate. Such list shall be organized by region and, if practicable, by major cities, counties, or geographic designations within each region.

(B) The Secretary shall make such list available in each district office of the Social Security Administration and at such other locations as the Secretary determines to be appropriate.

* * * * * * *

APPROPRIATIONS TO COVER GOVERNMENT CONTRIBUTIONS AND CONTINGENCY RESERVE

SEC. 1844. (a) There are authorized to be appropriated from time to time, out of any moneys in the Treasury not otherwise appropriated, to the Federal Supplementary Medical Insurance Trust Fund—

(1)(A) a Government contribution equal to the aggregate premiums payable for a month for enrollees age 65 and over under this part and deposited in the Trust Fund, multiplied by the ratio of—

(i) twice the dollar amount of the actuarially adequate rate per enrollee age 65 and over as determined under section 1839(a)(1) for such month minus the dollar amount of the premium per enrollee for such month as determined under section [1839(a)(3) or 1839(e), as the case may be] *1839(c)(2)* to

(ii) the dollar amount of the premium per enrollee for such month, plus

(B) a Government contribution equal to the aggregate premiums payable for a month for enrollees under age 65 under this part and deposited in the Trust Fund, multiplied by the ratio of—

(i) twice the dollar amount of the actuarially adequate rate per enrollee under age 65 as determined under section 1839(a)(4) for such month minus the dollar amount of the premium per enrollee for such month as determined under section [1839(a)(3) or 1839(e), as the case may be] *1839(c)(2)* to

(ii) the dollar amount of the premium per enrollee for such month.

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PART C—MISCELLANEOUS PROVISIONS

DEFINITION OF SERVICES, INSTITUTIONS, ETC.

SEC. 1861. For purposes of this title—

* * * * * * *

[Inpatient Tuberculosis Hospital Services

[(d) The term "inpatient tuberculosis hospital services" means inpatient hospital services furnished to an inpatient of a tuberculosis hospital.]

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Hospital

(e) The term "hospital" (except for purposes of sections 1814(d), 1814(f) and 1835(b), subsection (a)(2) of this section, paragraph (7) of this subsection, and subsection (i) of this section) means an institution which—

* * * * * * *

(9) meets such other requirements as the Secretary finds necessary in the interest of the health and safety of the individuals who are furnished services in the institution.

For purposes of subsection (a)(2), such term includes any institution which meets the requirements of paragraph (1) of this subsection. For purposes of sections 1814(d) and 1835(b) (including determination of whether an individual received inpatient hospital services or diagnostic services for purposes of such sections), section 1814(f)(2), and subsection (i) of this section, such term includes any institution which (i) meets the requirements of paragraphs (5) and (7) of this subsection, (ii) is not primarily engaged in providing the services described in section 1861(j)(1)(A) and (iii) is primarily engaged in providing, by or under the supervision of individuals referred to in paragraph (1) of section 1861(r) to inpatients diagnostic services and therapeutic services for medical diagnosis, treatment, and care of injured, disabled, or sick persons, or rehabilitation services for the rehabilitation of injured, disabled, or sick persons. For purposes of section 1814(f)(1), such term includes an institution which (i) is a hospital for purposes of sections 1814(d), 1814(f)(2), and 1835(b) and (ii) is accredited by the Joint Commission on Accreditation of Hospitals, or is accredited by or approved by a program of the country in which such institution is located if the Secretary finds the accreditation or comparable approval standards of such program to be essentially equivalent to those of the Joint Commission on Accreditation of Hospitals. Notwithstanding the preceding provisions of this subsection, such term shall not, except for purposes of subsection (a)(2), include any institution which is primarily for the care and treatment of mental diseases [or tuberculosis unless it is a tuberculosis hospital (as defined in subection (g))] or unless it is a psychiatric hospital (as defined in subsection (f)). The term "hospital" also includes a Christian Science sanatorium operated, or listed and certified, by the First Church of Christ, Scientist, Boston, Massachusetts, but only with respect to items and services ordinarily furnished by such institution to inpatients, and payment may be made with respect to services provided by or in such an institution only to such extent and under such conditions, limitations, and requirements (in addition to or in lieu of the conditions, limitations, and requirements otherwise applicable) as may be provided in regulations. For provisions deeming certain requirements of this subsection to be met in the case of accredited institutions, see section 1865. The term "hospital" also includes a facility of fifty beds or less which is located in an area determined by the Secretary to meet the definition relating to a rural area described in subparagraph (A) of paragraph (5) of this subsection and

which meets the other requirements of this subsection, except that—

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[Tuberculosis Hospital

[(g) The term "tuberculosis hospital" means an institution which—

[(1) is primarily engaged in providing, by or under the supervision of a physician, medical services for the diagnosis and treatment of tuberculosis;

[(2) satisfies the requirements of paragraphs (3) through (9) of subsection (e);

[(3) maintains clinical records on all patients and maintains such records as the Secretary finds to be necessary to determine the degree and intensity of the treatment provided to individuals covered by the insurance program established by part A;

[(4) meets such staffing requirements as the Secretary finds necessary for the institution to carry out an active program of treatment for individuals who are furnished services in the institution; and

[(5) is accredited by the Joint Commission on Accreditation of Hospitals.

In the case of an institution which satisfies paragraphs (1) and (2) of the preceding sentence and which contains a distinct part which also satisfies paragraphs (3) and (4) of such sentence, such distinct part shall be considered to be a "tuberculosis hospital" if the institution is accredited by the Joint Commission on Accreditation of Hospitals or if such distinct part meets requirements equivalent to such accreditation requirements as determined by the Secretary.]

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Skilled Nursing Facility

(j) The term "skilled nursing facility" means (except for purposes of subsection (a)(2)) an institution (or a distinct part of an institution) which has in effect a transfer agreement (meeting the requirements of subsection (1)) with one or more hospitals having agreements in effect under section 1866 and which—

* * * * * * *

(15) meets such other conditions relating to the health and safety of individuals who are furnished services in such institution or relating to the physical facilities thereof as the Secretary may find necessary (subject to the second sentence of section 1863), except that the Secretary shall not require as a condition of participation that medical social services be furnished in any such institution. Notwithstanding any other provision of law, all information concerning skilled nursing facilities required by this subsection to be filed with the Secretary shall be made available to Federal or State employees for purposes consistent with the effective administration of programs established under titles XVIII and XIX of this Act;

except that such term shall not (other than for purposes of subsection (a)(2)) include any institution which is primarily for the care and treatment of mental diseases [or tuberculosis]. For purposes of subsection (a)(2), such term includes any institution which meets the requirements of paragraph (1) of this subsection. The term "skilled nursing facility" also includes an institution described in paragraph (1) of subsection (y), to the extent and subject to the limitations provided in such subsection.

* * * * * * *

EXCLUSIONS FROM COVERAGE

SEC. 1862. (a) * * *

(b)(1) Payment under this title may not be made with respect to any item or service to the extent that payment has been made, or can reasonably be expected to be made *promptly* (as determined in accordance with regulations), with respect to such item or service, under a workmen's compensation law or plan of the United States or a State or under an automobile or liability insurance policy or plan (including a self-insured plan) or under no fault insurance. Any payment under this title with respect to any item or service shall be conditioned on reimbursement to the appropriate Trust Fund established by this title when notice or other information is received that payment for such item or service has been *or could be* made under such a law, policy, plan, or insurance. *In order to recover payment made under this title for an item or service, the United States may bring an action against any entity that would be responsible for payment with respect to such item or service (or any portion thereof) under such a law, policy, plan, or insurance, or against any individual or entity that has been paid with respect to such item or service under such law, policy, plan, or insurance, and may join or intervene in any action related to the events that gave rise to the need for such item or service. The United States shall be subrogated (to the extent of payment made under this title for an item or service) to any right of the individual or any other entity to payment with respect to such item or service under such a law, policy, plan, or insurance.* The Secretary may waive the provisions of this subsection in the case of an individual claim if he determines that the probability of recovery or amount involved in such claim does not warrant the pursuing of the claim.

(2)(A) In the case of an individual who is entitled to benefits under part A or is eligible to enroll under part B solely by reason of section 226A, payment under this title may not be made, except as provided in subparagraph (B), with respect to any item or service furnished during the period described in subparagraph (C) to the extent that payment with respect to expenses for such item or service (i) has been made under any group health plan (as defined in section 162(i)(2) of the Internal Revenue Code of 1954) or (ii) the Secretary determines will be made under such a plan as promptly as would otherwise be the case if payment were made by the Secretary under this title.

(B) Any payment under this title with respect to any item or service furnished to an individual described in subparagraph (A) during the period described in subparagraph (C) shall be condition-

ed on reimbursement to the appropriate Trust Fund established by this title when notice or other information is received that payment for such item or service has been *or could be* made under a plan described in subparagraph (A). *In order to recover payment made under this title for an item or service, the United States may bring an action against an entity that would be responsible for payment with respect to such item or service (or any portion thereof) under such a plan, or against any individual or entity that has been paid with respect to such item or service under such plan, and may join or intervene in any action related to the events that gave rise to the need for such item or service. The United States shall be subrogated (to the extent of payment made under this title for an item or service) to any right of the individual or any other entity to payment with respect to such item or service under such a plan.* The Secretary may waive the provisions of this subparagraph in the case of an individual claim if he determines that the probability of recovery or amount involved in such claim does not warrant the pursuing of the claim.

(C) The provisions of subparagraphs (A) and (B) shall apply to an individual only during the 12-month period which begins with the earlier of—

(i) the month in which a regular course of renal dialysis is initiated, or

(ii) in the case of an individual who receives a kidney transplant, the first month in which he would be eligible for benefits under this title (if he had filed an application for such benefits) under the provisions of section 226(A)(b)(1)(B).

(D) Where payment for an item or service under such plan is less than the amount of the charge for such item or service, payment may be made under this title (without regard to deductibles and coinsurance under this title) for the remainder of such charge, but—

(i) such payment under this title may not exceed an amount which would be payable under this title for such item or service in the absence of such group health plan; and

(ii) such payment under this title, when combined with the amount payable under such plan, may not exceed the combined amount which would have been payable under this title and such plan if this paragraph were not in effect.

(3)(A)(i) Payment under this title may not be made, except as provided in clause (ii), with respect to any item or service furnished during the period described in clause (iii) to an individual who is over 64 but under 70 years of age (or to the spouse of such individual, if the spouse is over 64 but under 70 years of age) who is employed at the time such item or service is furnished to the extent that payment with respect to expenses for such item or service has been made, or can reasonably be expected to be made, under a group health plan (as defined in cluause (iv)) under which such individual is covered by reasons of such employment.

(ii) Any payment under this title with respect to any item or service during the period described in clause (iii) shall be conditioned on reimbursement to the appropriate Trust Fund established by this title when notice or other information is received that payment for such item or service has been *or could be* made under a group health plan. *In order to recover payment made under this*

title for an item or service, the United States may bring an action against any entity that would be responsible for payment with respect to such item or service (or any portion thereof) under such a plan, or against any individual or entity that has been paid with respect to such item or service under such plan, and may join or intervene in any action related to the events that gave rise to the need for such item or service. The United States shall be subrogated (to the extent of payment made under this title for an item or service) to any right of the individual or any other entity to payment with respect to such item or service under such a plan. The Secretary may waive the provisions of this clause in the case of an individual claim if he determines that the probability of recovery or amount involved in such claim does not warrant the pursuing of the claim.

(iii) The provisions of clauses (i) and (ii) shall apply to an individual only for the period beginning with the month in which such individual becomes entitled to benefits under this title under section 226(a) and ending with the month in which such individual attains the age of 70 and shall not include any month for which the individual would, upon application, be entitled to benefits under section 226A.

(iv) For purposes of this paragraph, the term 'group health plan' has the meaning given to such term in section 162(i)(2) of the Internal Revenue Code of 1954.

(B) Where payment for an item or service under a group health plan is less than the amount of the charge for such item or service, payment may be made under this title (without regard to deductibles, and coinsurance under this title) for the remainder of such charge, but—

(i) such payment under this title may not exceed an amount which would be payable under this title for such item or service in the absence of such group health plan; and

(ii) such payment under this title, when combined with the amount payable under such plan, may not exceed—

(I) in the case of an item or service payment for which is determined under this title on the basis of reasonable cost (or other cost-related basis) or under section 1886, the amount which would be payable under this title on such basis; and

(II) in the case of an item or service for which payment is authorized under this title on another basis, the greater of—

(a) the amount which would be payable under the group health plan (without regard to deductibles and coinsurance under such plan), or

CONSULTATION WITH STATE AGENCIES AND OTHER ORGANIZATIONS TO DEVELOP CONDITIONS OF PARTICIPATION FOR PROVIDERS OF SERVICES

SEC. 1863. In carrying out his functions, relating to determination of conditions of participation by providers of services, under subsections (e)(9), (f)(4), [(g)(4),] (j)(11), (o)(6), (cc)(2)(I), and (dd)(2) of section 1861, or by ambulatory surgical centers under section 1832 (a)(2)(F)(i), the Secretary shall consult with [the Health Insurance Benefits Advisory Council established by section 1867, appropriate

State agencies,] *appropriate State agencies* and recognized national listing or accrediting bodies, and may consult with appropriate local agencies. Such conditions prescribed under any of such subsections may be varied for different areas or different classes of institutions or agencies and may, at the request of a State, provide higher requirements for such State than for other States; except that, in the case of any State or political subdivision of a State which imposes higher requirements on institutions as a condition to the purchase of services (or of certain specified services) in such institutions under a State plan approved under title I, XVI, or XIX, the Secretary shall impose like requirements as a condition to the payment for services (or for the services specified by the State or subdivision) in such institutions in such State or subdivision.

* * * * * * *

EFFECT OF ACCREDITATION

SEC. 1865. (a) Except as provided in subsection (b) and the second sentence of section 1863, if—

(1) an institution is accredited as a hospital by the Joint Commission on Accreditation of Hospitals, and

(2) such institution (if it is included within a survey described in section 1864(c)) authorizes the Commission to release to the Secretary [(on a confidential basis)] upon his request (or such State agency as the Secretary may designate) a copy of the most current accreditation survey of such institution made by such Commission,

then, such institution shall be deemed to meet the requirements of the numbered paragraphs of section 1861(e); except—

(3) paragraph (6) thereof, and

(4) any standard, promulgated by the Secretary pursuant to paragraph (9) thereof, which is higher than the requirements prescribed for accreditation by such Commission.

If such Commission, as a condition for accreditation of a hospital, requires a utilization review plan (or imposes another requirement which serves substantially the same purpose) or imposes a standard which the Secretary determines is at least equivalent to the standard promulgated by the Secretary as described in paragraph (4) of this subsection, the Secretary is authorized to find that all institutions so accredited by such Commission comply also with section 1861(e)(6) or the standard described in such paragraph (4), as the case may be. In addition, if the Secretary finds that accreditation of an [institution or agency] *entity* by the American Osteopathic Association or any other national accreditation body provides reasonable assurance that any or all of the conditions of [section 1861 (e), (j), or (o), or (dd)] *section 1832(a)(2)(F)(i), 1861(e), 1861(j), 1861(o), 1861(p)(4) (A) or (B), paragraphs (11) and (12) of section 1861(s), section 1861(aa)(2), 1861(cc)(2), or 1861(dd)(2),* as the case may be, are met, he may, to the extent he deems it appropriate, treat such [institution or agency] *entity* as meeting the condition or conditions with respect to which he made such finding. *The Secretary may not disclose any accreditation survey made and released to him by the Joint Commission on Accreditation of Hospitals, the Ameri-*

can Osteopathic Association, or any other national accreditation body, of an entity accredited by such body.

* * * * * * *

AGREEMENTS WITH PROVIDERS OF SERVICES

SEC. 1866. (a)(1) * * *

(b) An agreement with Secretary under this section may be terminated—* * *

Any termination shall be applicable—

(3) in the case of inpatient hospital services (including [tuberculosis hospital services and] inpatient psychiatric hospital services) or post-hospital extended care services, with respect to services furnished after the effective date of such termination, except that payment may be made for up to thirty days with respect to inpatient institutional services furnished to any eligible individual who was admitted to such institution prior to the effective date of such termination,

* * * * * * *

(4)(A) with respect to home health service or hospital care furnished to an individual under a plan therefor established on or after the effective date of such termination, or (B) if a plan is established before such effective date, with respect to such services furnished to such individual [after the calendar year in which such termination is effective] *more than 30 days after such effective date,* and

(5) with respect to any other items and services furnished on or after the effective date of such termination.

(d) If the Secretary finds that there is a substantial failure to make timely review in accordance with section 1861(k) of long-stay cases in a hospital or skilled nursing facility, he may, in lieu of terminating his agreement with such hospital or facility, decide that, with respect to any individual admitted to such hospital or facility after a subsequent date specified by him, no payment shall be made under this title for inpatient hospital services (including [inpatient tuberculosis hospital services and] inpatient psychiatric hospital services) after the 20th day of a continuous period of such services or for post-hospital extended care services after such day of a continuous period of such care as is prescribed in or pursuant to regulations, as the case may be. Such decision may be made effective only after such notice to the hospital, or (in the case of a skilled nursing facility) to the facility and the hospital or hospitals with which it has transfer agreement, and to the public, as may be prescribed by regulations, and its effectiveness shall terminate when the Secretary finds that the reason therefor has been removed and that there is reasonable assurance that it will not recur. The Secretary shall not make any such decision except after reasonable notice and opportunity for hearing to the institution or agency affected thereby.

* * * * * * *

[HEALTH INSURANCE BENEFITS ADVISORY COUNCIL

[SEC. 1867. (a) There is hereby created a Health Insurance Benefits Advisory Council which shall consist of 19 persons, not otherwise in the employ of the United States, appointed by the Secretary without regard to the provisions of title 5, United States Code, governing appointments in the competitive services. The Secretary shall from time to time appoint one of the members to serve as Chairman. The members shall include persons who are outstanding in fields related to hospital, medical, and other health activities, persons who are representative of organizations and associations of professional personnel in the field of medicine, and at least one person who is representative of the general public. Each member shall hold office for a term of four years, except that any member appointed to fill a vacancy occurring prior to the expiration of the term for which his predecessor was appointed shall be appointed for the remainder of such term. A member shall not be eligible to serve continuously for more than two terms. Members of the Advisory Council, while attending meetings or conferences thereof or otherwise serving on business of the Advisory Council, shall be entitled to receive compensation at rates fixed by the Secretary, but not exceeding $100 per day, including traveltime, and while so serving away from their homes or regular places of business they may be allowed travel expenses, including per diem in lieu of subsistence, as authorized by section 5703 of title 5, United States Code, for persons in the Government service employed intermittently. The Advisory Council shall meet as the Secretary deems necessary, but not less than annually.

[(b) It shall be the function of the Advisory Council to provide advice and recommendations for the consideration of the Secretary on matters of general policy with respect to this title and title XIX.]

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MEDICARE COVERAGE FOR END STAGE RENAL DISEASE PATIENTS

SEC. 1881. * * *

(c) (1) * * *

(3) Where the Secretary determines, on the basis of the data contained in the network's annual report and such other relevant data as may be available to him, that a facility or provider has consistently failed to cooperate with network plans and goals, he may terminate or withhold certification of such facility or provider (for purposes of payment for services furnished to individuals with end stage renal disease) until he determines that such provider or facility is making reasonable and appropriate efforts to cooperate with the network's plans and goals. *If the Secretary determines that the facility's or provider's failure to cooperate with network plans and goals does not jeopardize patient health or safety or justify termination of certification, he may instead, after reasonable notice to the provider or facility and to the public, impose such other sanctions as he determines to be appropriate, which sanctions may include denial of reimbursement with respect to some or all patients*

admitted to the facility after the date of the notice, and graduated reduction in reimbursement for all patients.

* * * * * * *

[PAYMENTS TO PROMOTE CLOSING AND CONVERSIONS OF UNDERUTILIZED HOSPITAL FACILITIES

[SEC. 1884. (a) Any hospital may file an application with the Secretary (in such form and including such data and information as the Secretary may require) for establishment of a transitional allowance under this title with respect to the closing or conversion of an underutilized hospital facility. The Secretary also may establish procedures, consistent with this section, by which a hospital, before undergoing an actual closure or conversion of a hospital facility, can have a determination made as to whether or not it will be eligible for a transitional allowance under this section with respect to such closure or conversion.

[(b) If the Secretary finds, after consideration of an application under subsection (a), that—

[(1) the hospital's closure or conversion—

[(A) is formally initiated after September 30, 1981,

[(B) is expected to benefit the program under this title by (i) eliminating excess bed capacity, (ii) discontinuing an underutilized service for which there are adequate alternative sources, or (iii) substituting for the underutilized service some other service which is needed in the area, and

[(C) is consistent with the findings of an appropriate health planning agency and with any applicable State program for reduction in the number of hospital beds in the State, and

[(2) in the case of a complete closure of a hospital—

[(A) the hospital is a private nonprofit hospital or a local governmental hospital, and

[(B) the closure is not for replacement of the hospital,

the Secretary may include as an allowable cost in the hospital's reasonable cost (for the purpose of making payments to the hospital under this title) an amount (in this section referred to as a "transitional allowance), as provided in subsection (c).

[(c)(1) Each transitional allowance established shall be reasonably related to the prior or prospective use of the facility involved under this title and shall recognize—

[(A) in the case of a facility conversion or closure (other than a complete closure of a hospital—

[(i) in the case of a private nonprofit or local governmental hospital, that portion of the hospital's costs attributable to capital assets of the facility which have been taken into account in determining reasonable cost for purposes of determining the amount of payment to the hospital under this title, and

[(ii) in the case of any hospital, transitional operating cost increases related to the conversion or closure to the extent that such operating costs exceed amounts ordinarily reimbursable under this title; and

[(B) in the case of complete closure of a hospital, the outstanding portion of actual debt obligations previously recognized as reasonable for purposes of reimbursement under this title, less any salvage value of the hospital.

[(2) A transitional allowance shall be for a period (not to exceed 20 years) specified by the Secretary, except that, in the case of a complete closure described in paragraph (1)(B), the Secretary may provide for a lump-sum allowance where the Secretary determines that such a one-time allowance is more efficient and economical.

[(3) A transitional allowance shall take effect on a date established by the Secretary, but not earlier than the date of completion of the closure or conversion concerned.

[(4) A transitional allowance shall not be considered in applying the limits to costs recognized as reasonable pursuant to the third sentence of subparagraph (A) and subparagraph (L)(i) of section 1861(v)(1) of this Act, or in determining whether the reasonable cost exceeds the customary charges for a service for purposes of determining the amount to be paid to a provider pursuant to sections 1814(b) and 1833(a)(2) of this Act.

[(d) A hospital dissatisfied with a determination of the Secretary on its application under this section may obtain an informal or formal hearing, at the discretion of the Secretary, by filing (in such form and within such time period as the Secretary establishes) a request for such a hearing. The Secretary shall make a final determination on such application within 30 days after the last day of such hearing.]

TITLE XIX—GRANTS TO STATES FOR MEDICAL ASSISTANCE PROGRAMS

* * * * * * *

STATE PLANS FOR MEDICAL ASSISTANCE

SEC. 1902. (a) A State plan for medical assistance must—

* * * * * * *

(28) provide that any skilled nursing facility receiving payments under such plan must satisfy all of the requirements contained in section 1861(j), except that the exclusion contained therein with respect to institutions which are primarily for the care and treatment of mental diseases [and tuberculosis] shall not apply for purposes of this title;

* * * * * * *

[(31) provide (A) for a regular program of independent professional review (including medical evaluation of each patient's need for intermediate care) and a written plan of service prior to admission or authorization of benefits in an intermediate care facility as determined under regulations of the Secretary; (B) for periodic on-site inspections to be made in all such intermediate care facilities (if the State plan includes care in such institutions) within the State by one or more independent professional review teams (composed of physicians or registered nurses and other appropriate health and social service personnel) of (i) the care being provided in such intermediate care facilities to persons receiving assistance under the State plan,

(ii) with respect to each of the patients receiving such care, the adequacy of the services available in particular intermediate care facilities to meet the current health needs and promote the maximum physical well-being of patients receiving care in such facilities, (iii) the necessity and desirability of the continued placement of such patients in such facilities, and (iv) the feasibility of meeting their health care needs through alternative institutional or non-institutional services; and (C) for the making by such team or teams of full and complete reports of the findings resulting from such inspections, together with any recommendations to the State agency administering or supervising the administration of the State plan;]

(31) With respect to skilled nursing facilities (and with respect to intermediate care facility services, where the State plan includes medical assistance for such services) provide—

(A) with respect to each patient receiving such assistance, for a written plan of care, prior to admission to or authorization of benefits in such facility, in accordance with regulations of the Secretary, and for a regular program of independent professional review (including medical evaluation) which shall periodically review his need for such care;

(B) with respect to each facility within the State, for periodic on-site inspections of the care being provided to each person receiving medical assistance, by one or more independent professional review teams (composed of a phyisican or registered nurse and other appropriate health and social service personnel), including with respect to each such person (i) the adequacy of the services available to meet his current health needs and promote his maximum physical well-being,(ii) the necessity and desirability of his continued placement in the facility, and (iii) the feasibility of meeting his health care needs through alternative institutional or noninstitutional services; and

(C) for full reports to the State agency by each independent professional review team of the findings of each inspection under subparagraph (B), together with any recommendations;".

(b) Section 1902(a)(26) of the Social Security Act is amended to read as follows:

(26) if the State plan includes medical assistance for inpatient mental hospital services provide—

(A) with respect to each patient receiving such assistance, for a regular program of medical review (including medical evaluation) of his need for such care, and for a written plan of care;

(B) for periodic inspections to be made in all mental institutions within the State by one or more medical review teams (composed of physicians and other appropriate health and social service personnel) of the care being provided to each person receiving such assistance, including (i) the adequacy of the services available to meet his current health needs and promote his maximum physical well-being, (ii) the necessity and desirability of his continued placement in the institution, and (iii) the feasibility of

meeting his health care needs through alternative institutional or noninstitutional services; and

(C) for full reports to the State agency by each medical review team of the findings of each inspection under subparagraph (B), together with any recommendations;

* * * * * * *

(43) if the State plan makes provision for payment to a physician for laboratory services the performance of which such physician (or any other physician with whom he shares his practice) did not personally perform or supervise, include provision to insure that payment under the State plan for such laboratory services not exceed the payment authorized for such services by section 1842(h); [and]

(44) provide for—

(A) informing all persons in the State who are under the age of 21 and who have been determined to be eligible for medical assistance including services described in section 1905(a)(4)(B), of the availability of early and periodic screening, diagnostic, and treatment services as described in section 1905(a)(4)(B),

(B) providing or arranging for the provision of such screening services in all cases where they are requested, and

(C) arranging for (directly or through referral to appropriate agencies, organizations, or individuals) corrective treatment the need for which is disclosed by such child health screening services[.] *; and*

(45) provide that during the period beginning on August 1, 1983, and ending on July 30, 1985, any pregnant woman who the State has the option of deeming to be a recipient of aid to families with dependent children for purposes of this title by reason of section 406(g)(2), shall be deemed to be such a recipient for purposes of this title.

Notwithstanding paragraph (5), if on January 1, 1965, and on the date on which a State submits its plan for approval under this title, the State agency which administered or supervised the administration of the plan of such State approved under title X (or title XVI, insofar as it relates to the blind) was different from the State agency which administered or supervised the administration of the State plan approved under title I (or title XVI, insofar as it relates to the aged), the State agency which administered or supervised the administration of such plan approved under title X (or title XVI, insofar as it relates to the blind) may be designated to administer or supervise the administration of the portion of the State plan for medical assistance which relates to blind individuals and a different State agency may be established or designated to administer or supervise the administration of the rest of the State plan for medical assistance; and in such case the part of the plan which each such agency administers, or the administration of which each such agency supervises, shall be regarded as a separate plan for purposes of this title (except for purposes of paragraph (10)). For purposes of paragraphs (9)(A) [(26),] (29), (31), and (33), and of section 1903(i)(4), [the term "skilled nursing facility" and "nursing

home"] *the terms "skilled nursing facility", "intermediate care facility", and "nursing home"* do not include a Christian Science sanatorium operated, or listed and certified, by the First Church of Christ Scientist, Boston, Massachusetts.

* * * * * * *

PAYMENT TO STATES

SEC. 1903. (a) * * *

[(e) A State plan approved under this title may include, as a cost with respect to hospital services under the plan under this title, periodic expenditures made to reflect transitional allowances established with respect to a hospital closure or conversion under section 1884.]

* * * * * * *

(g)(1) Subject to paragraph (3), with respect to amounts paid for the following services furnished under the State plan after June 30, 1973 (other than services furnished pursuant to a contract with a health maintenance organization as defined in section 1876 or which is a qualified health maintenance organization (as defined in section 1310(d) of the Public Health Service Act)), the Federal medical assistance percentage shall be decreased as follows: After an individual has received care as an inpatient in a hospital [(including an institution for tuberculosis)], skilled nursing facility or intermediate care facility on 60 days, or in a hospital for mental diseases on 90 days (whether or not such days are consecutive), during any fiscal year, which for purposes of this section means the four calendar quarters ending with June 30, the Federal medical assistance percentage with respect to amounts paid for any such care furnished thereafter to such individual in the same fiscal year shall be decreased by a per centum thereof (determined under paragraph (5)) unless the State agency responsible for the administration of the plan makes a showing satisfactory to the Secretary that, with respect to each calendar quarter for which the State submits a request for payment at the full Federal medical assistance percentage for amounts paid for inpatient hospital services [(including tuberculosis hospitals)], skilled nursing facility services, or intermediate care facility services furnished beyond 60 days (or inpatient mental hospital services furnished beyond 90 days), there is in operation in the State an effective program of control over utilization of such services; such a showing must include evidence that—

* * * * * * *

DEFINITIONS

SEC. 1905. For purposes of this title—

(a) The term "medical assistance" means payment of part or all of the cost of the following care and services (if provided in or after the third month before the month in which the recipient makes application for assistance) for individuals, and, with respect to physicians' or dentists' services, at the option of the State, to individuals (other than individuals with respect to whom there is being paid, or who are eligible, or would be eligible if they were not in a medi-

cal institution, to have paid with respect to them a State supplementary payment and are eligible for medical assistance equal in amount, duration, and scope to the medical assistance made available to individuals described in section 1902(a)(10)(A)) not receiving aid or assistance under any plan of the State approved under title I, X, XIV, or XVI, or part A of title IV, and with respect to whom supplemental security income benefits are not being paid under the title XVI, who are

(i) under the age of 21, or, at the option of the State, under the age of 20, 19, or 18 as the State may choose,

(ii) relatives specified in section 406(b)(1) with whom a child is living if such child is (or would, if needy, be) a dependent child under part A of title IV,

(iii) 65 years of age or older,

(iv) blind, with respect to States eligible to participate in the State plan program established under title XVI,

(v) 18 years of age or older and permanently and totally disabled, with respect to States eligible to participate in the State plan program established under title XVI,

(vi) persons essential (as described in the second sentence of this subsection) to individuals receiving aid or assistance under State plans approved under title I, X, XIV, or XVI,

(vii) blind or disabled as defined in section 1614, with respect to States not eligible to participate in the State plan program established under the title XVI, or

(viii) pregnant women

but whose income and resources are insufficient to meet all of such cost—

(1) inpatient hospital services (other than services in an institution for [tuberculosis or] mental disease);

(2)(A) outpatient hospital services, and (B) consistent with State law permitting such services, rural health clinic services (as defined in subsection (1) and any other ambulatory services which are offered by a rural health clinic (as defined in subsection (1)) and which are otherwise included in the plan;

(3) other laboratory and X-ray services;

(4)(A) skilled nursing facility services (other than services in an institution for [tuberculosis or] mental diseases) for individuals 21 years of age or older (B) effective July 1, 1969, such early and periodic screening and diagnosis of individuals who are eligible under the plan and are under the age of 21 to ascertain their physical or mental defects, and such health care, treatment, and other measures to correct or ameliorate defects and chronic conditions discovered thereby, as may be provided in regulations of the Secretary; and (C) family planning services and supplies furnished (directly or under arrangments with others) to individuals of child-bearing age (including minors who can be considered to be sexually active) who are eligible under the State plan and who desire such services and supplies;

(5) physicians' services furnished by a physician (as defined in section 1861(r)(1)), whether furnished in the office, the patient's home, a hospital, or a skilled nursing facility, or elsewhere;

(6) medical care, or any other type of remedial care recognized under State law, furnished by licensed practitioners within the scope of their practice as defined by State law;

(7) home health care services;

(8) private duty nursing services;

(9) clinic services;

(10) dental services;

(11) physical therapy and related services;

(12) prescribed drugs, dentures, and prosthetic devices, and eyeglasses prescribed by a physician skilled in diseases of the eye or by an optometrist, whichever the individual may select;

(13) other diagnostic, screening, preventive, and rehabilitative services;

(14) inpatient hospital services, skilled nursing facility services, and intermediate care facility services for individuals 65 years of age or over in an institution for [tuberculosis or] mental diseases;

(15) intermediate care facility services (other than such services in an institution for [tuberculosis or] mental diseases) for individuals who are determined, in accordance with section 1902(a)(31)(A), to be in need of such care;

(16) effective January 1, 1973, inpatient psychiatric hospital services for individuals under age 21, as defined in subsection (h);

(17) services furnished by a nurse-midwife (as defined in subsection (m)) which she is legally authorized to perform under State law (or the State regulatory mechanism provided by State law), whether or not she is under the supervision of, or associated with, a physician or other health care provider; and

(18) any other medical care, and any other type of remedial care recognized under State law, specified by the Secretary;

except as otherwise provided in paragraph (16), such term does not include—

(A) any such payments with respect to care or services for any individual who is an inmate of a public institution (except as a patient in a medical institution); or

(B) any such payments with respect to care or services for any individual who has not attained 65 years of age and who is a patient in an institution for [tuberculosis or] mental diseases.

* * * * * * *

HOSPITAL PROVIDERS OF SKILLED NURSING AND INTERMEDIATE CARE SERVICES

SEC. 1913. (a) Notwithstanding any other provision of this title, payment may be made, in accordance with this section, under a State plan approved under this title for skilled nursing facility services and intermediate care facility services furnished by a hospital which has in effect an agreement under section 1883.

[(b)(1) Payment to any hospital, for any skilled nursing or intermediate care facility services furnished pursuant to subsection (a), shall be at a rate equal to the average rate per patient-day paid for routine services during the previous calendar year under the State

in which the hospital is located. The reasonable cost of ancillary services shall be determined in the same manner as the reasonable cost of ancillary services provided for inpatient hospital services.

[(2) With respect to any period for which a hospital has an agreement under section 1883, in order to allocate routine costs between hospital and long-term care services, the total reimbursement for routine services due from all classes of long-term care patients (including title XVIII, title XIX, and private pay patients) shall be subtracted from the hospital total routine costs before calculations are made to determine reimbursement for routine hospital services under the State plan.]

(b) Payment to any such hospital, for any skilled nursing or intermediate care facility services furnished pursuant to subsection (a), shall be at a payment rate established by the State in accordance with the requirements of section 1902(a)(13)(A). Such rate may, but need not, be the same as any rate established by the State for such services furnished by a skilled nursing or intermediate care facility.

* * * * * * *

APPLICATION OF PROVISIONS OF TITLE II RELATING TO SUBPENAS

SEC. 1918. The provisions of subsections (d) and (e) of section 205 of this Act shall apply with respect to this title to the same extent as they are applicable with respect to title II.

* * * * * * *

HEALTH CARE FOR UNEMPLOYED WORKERS

SEC. 2008. (a)(1) Notwithstanding section 2005(a)(4) and any other provision of this title, any State (as defined in paragraph (4)) may establish a program under this section for providing health care coverage for unemployed workers, subject to the provisions of this section.

(2) The State may choose those groups of individuals (and their immediate families) who shall be covered under the program, the duration of such coverage, and the duration of the program, as the State determines to be appropriate, except that—

(A) no coverage may be provided to any individual (or his immediate family) unless such individual (i) is receiving regular, extended, or Federal supplemental compensation, railroad unemployment compensation, or any other Federal unemployment compensation, or (ii) is unemployed and has exhausted his rights to such compensation (other than for cause) by reason of payment of all such compensation for which he is eligible, within the prior 6 months, or (iii) was eligible for such compensation within the prior 30 days but lost such eligibility on account of employment;

(B) no coverage may be provided for the first 6 weeks during which an individual is eligible for compensation (referred to in subparagraph (A)) in a benefit year (as determined under the applicable unemployment compensation law);

(C) no coverage may be provided to any individual unless such individual was enrolled in a group health plan of the employer by whom he was employed at the time he last became eli-

gible for compensation described in subparagraph (A) (and in making a determination with respect to prior enrollment, and with respect to coverage described in subparagraphs (F) and (G), the State may use the broadest possible determination of proof);

(D) no coverage may be provided with respect to any services provided prior to August 1, 1983, or services provided for an individual prior to the time such individual is determined to be eligible under such program, or inpatient services provided in a continuous period which began prior to such date or such eligibility;

(E) no coverage may be provided for any individual who is otherwise eligible for medical assistance under the State plan under title XIX or who is eligible for benefits under title XVIII;

(F) no coverage may be provided for any individual who is covered under a group health plan for which a contribution toward the cost of the plan is being made by an employer, former employer, union, or any entity other than the individual, or who could have been so covered if an election had been made and premiums had been paid on a timely basis;

(G) no coverage may be provided for any individual who is covered under a group health plan of such individual's spouse for which a contribution toward the cost of the plan is being made by an employer, former employer, union, or any entity other than such spouse, or who could have been so covered if an election after the date of the enactment of this section had been made and premiums had been paid on a timely basis; and

(H) no coverage may be provided for any individual whose family income exceeds an amount equal to 100 percent of the median family income in such State for a family of the same size as such individual's family (and in making a determination with respect to an individual's family income, the State shall determine the declaration or proof of income to be required, the type of income to be included, and the time period over which the income is to be measured).

(3)(A) The Secretary may waive the requirements of paragraph (2)(H) to the extent that special circumstances permit presumptions about the family income of applicants which make it unnecessary to apply the means test described in such paragraph on a case by case basis.

(B) The provisions of paragraph (2)(H) shall not preclude a State from imposing a means test that is more restrictive than the test described in such paragraph.

(4) Notwithstanding section 1101(a)(1), for purposes of this section the term "State" means the 50 States, the District of Columbia, Puerto Rico, and the Virgin Islands.

(b)(1)(A) Services under the program established under this section may include only—

(i) inpatient hospital services;

(ii) emergency outpatient hospital services;

(iii) routine and emergency physician services (including those provided in health clinics but not including those provided in nursing care or intermediate care facilities);

(iv) prenatal, delivery, and post partum care;

(v) laboratory and diagnostic X-ray services;

(vi) x-ray, radium, and radioactive isotope therapy;

(vii) services of a nurse midwife, described in section 1905(a)(17); and

(viii) home health services in cases where the State determines that the coverage of such services is cost effective.

(B) The State must include under the program some ambulatory and some institutional services.

(C) No drugs or biologicals shall be included within the covered services described in subparagraph (A) unless provided as part of inpatient hospital services.

(2) The State shall determine the amount, duration, and scope of the covered services described in paragraph (1) which shall be included under the program, but in no event shall the amount, duration, or scope of such services under the program of such services included under the State plan for medical assistance for individuals described in sections 1902(a)(10)(A).

(3) Services may be provided through various arrangements made with providers by the State, but no such arrangement may provide services which are more generous than those provided under the State plan for medical assistance for individuals described in section 1902(a)(10)(A).

(4) No cash payments may be made under the program to individuals participating in the program.

(c)(1) The State may provide for a weekly contribution for any individual participating in the program under this section, without regard to whether such individual is receiving compensation (referred to in subsection (a)(2)(A)), but no such contribution may exceed an amount equal to 8 percent of the amount of compensation (referred to in subsection (a)(2)(A)) for which such individual is eligible for such week or for the last week for which he was eligible for such compensation. Such contributions may vary for individual coverage and family coverage and by provider arrangement.

(2)(A) The State may require that deductibles and coinsurance amounts be imposed for users of services under the program. If the State chooses to require such deductibles and coinsurance amounts, they shall be at least the same amounts imposed under the State plan for medical assistance for individuals described in section 1902(a)(10)(A), subject to the limitations in this paragraph.

(B) The estimated average monthly amount of such deductibles and coinsurance amounts for outpatient services may not exceed an amount equal to 5 percent of the average monthly benefit amount in such State for unemployment compensation referred to in subsection (a)(2)(A).

(C) The amount of such deductibles and coinsurance amounts for impatient services may not exceed the maximum amount of deductibles and coinsurance amount which could be imposed by the State under its State plan for medical assistance for individuals described in section 1905(a)(10)(A) consistent with the provisions of title XIX, subject to the limitations in subparagraphs (D) and (E) of this paragraph.

(D) No deductibles or coinsurance amounts may be imposed for prenatal, delivery, or post partum care.

(E) No deductibles or coinsurance amounts may be imposed until after public hearings which provide adequate notice and opportuni-

ty for public participation have been held by the State with respect to such imposition.

(F) Subject to the limitations specified in this paragraph, such deductibles and coinsurance amounts may vary with respect to diferent groupings of eligible individuals, different types of services, different provider arrangements, and various coverage periods.

(3) Any contribution amount imposed by the State must be used by the State to pay the State share of the cost of the program under this section, or to provide additional services or periods of coverage to individuals eligible for coverage under such program.

(d)(1) Payment by the State for services provided to individuals eligible for the program under this section shall be made through the same administrative mechanisms through which payments are generally made under the State plan for medical assistance under title XIX; however, the State may provide for arrangements with carriers or providers which provide for cost effective financing and delivery systems, and may selectively make arrangements with a specific group or provide for capitation reimbursement, but no such arrangement may provide for services which are more generous than those provided under the State plan for medical assistance for individuals described in section 1902(a)(10)(A). Services provided through a prepaid capitation arrangement need not be provided through an organization meeting the requirements of section 1903(m).

(2) Any limitations under the State plan for medical assistance on the amount that a provider of services may charge the recipient of such services shall also apply to the program under this section, except that contributions, deductibles, and coinsurance may be charged in accordance with subsection (c).

(e)(1) Determinations of qualification for coverage under the program under this section shall be made by the State agency administering the State's unemployment compensation law approved under section 3304 of the Internal Revenue Code of 1954. The State may administer the services program under this section directly through the State agency administering the State plan for medical assistance under title XIX of this Act, or through arrangements with others.

(2) Upon becoming eligible for compensation (referred to in subsection (a)(2)(A)), an individual shall be informed of the eligibility criteria for coverage under the program established under this section and the benefits provided, and shall have four weeks in which to voluntarily enroll in such program. Such individual shall also be informed of the possibility that such individual may be eligible to enroll in a health plan of his spouse. If the individual declines the opportunity to enroll, or later voluntarily terminates his enrollment, he may not again enroll in such program unless he subsequently becomes eligible for compensation (referred to in subsection (a)(2) (A)) for a new benefit year (as determined under the applicable unemployment compensation law).

(3) In the case of any State which chooses to require the payment of a contribution, the State may deduct the amount of the contribution from the amount of such compensation paid to an individual enrolled in such program.

(4) Any State which chooses to cover under its program individuals residing in such State who are or were receiving railroad unemployment compensation, may enter into an agreement with the Railroad Retirement Board under which—

(A) the Railroad Retirement Board shall notify those unemployed railroad workers who may be eligible under the program of the availability of the program in accordance with paragraph (2);

(B) the Board shall furnish the State agency making eligibility determinations with such information as the State agency may require in order to make eligibility determinations with respect to such unemployed railroad workers or shall, to the extent feasible, perform such determinations for the State agency;

(C) the Board shall deduct contribution amounts from any railroad unemployment compensation payable to such unemployed railroad workers in the same amounts as if such workers were receiving unemployment compensation under the State unemployment compensation law, and transfer such amounts to the State; and

(D) the state shall reimburse the Board for administrative costs incurred under such agreement, and such amounts shall be paid into the railroad unemployment insurance administration fund.

(5) The Railroad Retirement Board is authorized to carry out those functions required of it under any agreement entered into under paragraph (4).

(f)(1) Notwithstanding sections 2002 and 2003, payments to States having programs established under this section shall be made in accordance with the provisions of this subsection, but subject to subsection (g). Payments under this subsection are in addition to any amounts to which a State is entitled under section 2002, and payments made under section 2002 may not be used for purposes of this section. An amount, not to exceed the State's allotment determined under paragraph (2), equal to the Federal percentage (as determined under paragraph (6)) of the amount expended by such State for its program established under this section (excluding administrative costs) shall be paid to the State in the same manner as payments are made under section 1903(d).

(2) The Secretary shall allot $750,000,000 to carry out this section for each of the 12-month periods beginning on August 1, 1983, and August 1, 1984, among the States as follows:

(A) One-half of such amount shall be allocated among the States on the basis of the relative number of insured unemployed individuals who reside in each State as compared to the total number of insured unemployed individuals in all the States.

(B) One-half of such amount shall be allotted among the States on the basis of the relative number of individuals who have been employed for 26 weeks or more and who reside in each State as compared to the total number of such individuals in all the States.

(3) Allotments shall be made on the basis of the most recent 12-month period, preceeding the month in which the Secretary makes such allotments, for which adequate data is available.

(4) Funds shall be allotted at the beginning of each 12-month period referred to in paragraph (2), but payment shall be made as described in paragraph (1). Amounts allotted for the 12-month period beginning August 1, 1984, may be paid to States for expenses incurred in providing services under the program for individuals who are enrolled in the program on July 31, 1985, until their eligibility for such program terminates, or January 31, 1986, whichever is earlier.

(5) Any funds allotted for a 12-month period to a State which did not establish a program under this section shall be reallotted to those States having a program, at the end of such 12-month period. Such funds may be expended in the same manner as described in paragraph (4).

(6)(A) For purposes of this section, the Federal percentage is 100 percent with respect to services provided prior to February 1, 1984, and, with respect to services provided on or after February 1, 1984, is—

(i) 95 percent with respect to services provided in any State during a week for which the State's rate of insured unemployment (as determined for purposes of section 203 of the Federal-State Extended Unemployment Compensation Act of 1970) for the period consisting of such week and the preceding 51 weeks is equal to or exceeds 5 percent;

(ii) 80 percent with respect to services provided in any State during a week for which the State's rate of insured unemployment for the period consisting of such week and the preceding 51 weeks is equal to or exceeds 4 percent but is less than 5 percent;

(iii) 65 percent with respect to services provided in any State during a week for which the State's rate of insured unemployment for the period consisting of such week and the preceding 51 weeks is equal to or exceeds 3 percent but is less than 4 percent; and

(iv) 50 percent with respect to services provided in any State during a week for which the State's insured unemployment rate for the period consisting of such week and the preceding 51 weeks is less than 3 percent.

(B) The Federal percentage otherwise applicable under subparagraph (A) for any week beginning on or after February 1, 1984, shall be increased by 15 percentage points (but not to a percentage greater than 95 percent) with respect to services provided in any State during a week for which the State's rate of insured unemployment for the period consisting of such week and the preceding 51 weeks is equal to or exceeds 120 percent of the average of such rates for such State for the corresponding 52-week period ending in each of the preceding 2 calendar years.

(C) Any State which qualifies for a particular matching percentage under clause (i), (ii), (iii), or (iv) of subparagraph (A), or under subparagraph (B), shall continue at such percentage for a period of not less than 6 months, unless it subsequently qualifies for a higher percentage under such provisions, beginning with the first week in

which such State so qualifies, and may subsequently requalify for a particular higher matching percentage upon reaching the required rate of insured unemployment after the end of such 6-month period. No such period may extend beyond January 31, 1986. Notwithstanding the first sentence of this subparagraph, the matching percentage for each State with respect to services provided after July 31, 1985, and before February 1, 1986, shall be the matching percentage in effect for such States with respect to services provided on July 31, 1985.

(7) The Secretary shall make payments for administrative costs incurred in carrying out the program established under this section, in a total amount not to exceed $150,000,000 for each of the 12-month periods beginning on August 1, 1983, and August 1, 1984. Seventy million dollars of such reimbursement for each 12-month period shall be made to the State agencies administering the services program under this section in accordance with the allotment formula in paragraph (2), and $80,000,000 of such reimbursement for each 12-month period shall be made to the Department of Labor for payment to the State agencies (of those States having a program under this section) administering the State's unemployment compensation law in accordance with the distribution formula used for purposes of title III of this Act. Payments under this paragraph may be made with respect to program costs incurred after January 31, 1986.

(g)(1) Only a State having a rate of insured unemployment (as determined for purposes of section 203 of the Federal-State Extended Unemployment Compensation Act of 1970 for a period consisting of any week and the 51 preceding weeks, of 2 percent or more, may enroll new individuals in the program under this section during such week. If a State qualifies to enroll new individuals under the preceding sentence, such qualification shall continue for a period of not less than 6 months beginning with the first week in which such State so qualifies, and any State may subsequently requalify upon reaching the required rate of insured unemployment after the end of such 6-month period, but no such period may extend beyond January 31, 1986.

(2) During a period in which a State may not enroll new individuals in its program by reason of paragraph (1), payment under this section may be made with respect to individuals previously enrolled in such program until their eligibility expires, or, if sooner, January 31, 1986.

(h) Any State establishing a program under this section shall submit a report to the Secretary on June 1, 1984, on the program's implementation and impact. A final report shall be submitted in March 1986 by any State which carries out its program for any period after January 31, 1984, upon expiration of its program. The form and content of the reports required under this subsection shall be determined by the Secretary.

(i) The State shall provide that the payment for any services received by an individual under the program whall be secondary to, and shall be reduced by the amount of, any other payment which is or could be made with respect to such services under any other health plan or public program, or from a third party, including any workmen's compensation law or plan, any automobile or liability insurance policy or plan (including a self-insured plan), and any no

fault insurance. The State shall require each individual enrolled in the program to assign all rights to such payments as he may have to the State as a condition of enrolling in the program.

(j)(1) No payment may be made under this section to any State unless such State provides, subject to paragraph (2), that any group health plan for employees of such State, provided by such State or to which such State makes a contribution, provides for open enrollment in accordance with section 4912(b) of the Internal Revenue Code of 1954.

(2)(A) Except as provided in subparagraph (B), the requirements of paragraph (1) shall apply to enrollment periods for employees whose spouses are involuntarily laid off or separated more than 60 days after the date of the enactment of this section.

(B) In the case of a group health plan which was subject to a collective bargaining agreement in effect on the date of the enactment of this section, the date on which such agreement expires (determined without regard to any extensions agreed to after such date of enactment) shall, if later, be substituted for the date (60 days after such date of enactment) referred to in paragraph (1).

RAILROAD RETIREMENT ACT OF 1974

(Public Law 75–162)

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POWERS AND DUTIES OF THE BOARD

SEC. 7. * * *

(d)(1) * * *

(4) The rights of individuals described in subdivision (2) of this subsection to have payment made on their behalf for the services referred to in subdivision (1) but provided in Canada shall be the same as those of individuals to whom section 226 and part A of title XVIII of the Social Security Act apply, and this subdivision shall be administered by the Board as if the provisions of section 226 and part A of title XVIII of the Social Security Act were applicable, as if references to the Secretary of Health, Education, and Welfare were to the Board, as if references to the Federal Hospital Insurance Trust Fund were to the Railroad Retirement Account, as if references to the United States or a State included Canada or a subdivision thereof, and as if the provisions of sections 1862(a)(4), 1863, 1864, [1867,] 1868, 1869, 1874(b), and 1875 were not included in such title. The payments for services herein provided for in Canada shall be made from the Railroad Retirement Account (in accordance with, and subject to, the conditions applicable under section 7(b), in making payment of other benefits) to the hospital, extended care facility or home health agency providing such services in Canada to individuals to whom subdivision (2) of this subsection applies, but only to the extent that the amount of payments for services otherwise hereunder provided for an individual exceeds the amount payable for like services provided pursuant to the law in effect in the place in Canada where such services are furnished. For the purposes of section 10 of this Act, any overpayment under

this subdivision shall be treated as if it were an overpayment of an annuity.

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SOCIAL SECURITY AMENDMENTS OF 1967, AS AMENDED

(Public Law 90-248)

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INCENTIVES FOR ECONOMY WHILE MAINTAINING OR IMPROVING QUALITY IN THE PROVISION OF HEALTH SERVICES

SEC. 402. (a)(1) The Secretary of Health, Education, and Welfare is authorized, either directly or through grants to public or [nonprofit] private agencies, institutions, and organizations or contracts with public or private agencies, institutions, and organizations, to develop and engage in experiments and demonstration projects for the following purposes:

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SOCIAL SECURITY AMENDMENTS OF 1977

(Public Law 95-216)

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PART F—NATIONAL COMMISSION ON SOCIAL SECURITY

ESTABLISHMENT OF COMMISSION

SEC. 361. (a) * * *

[(i) It shall be the duty of the Health Insurance Benefits Advisory Council (established by section 1867 of the Social Security Act) to provide timely notice to the Commission of any meeting, and the Chairman of the Commission (or his delegate) shall be entitled to attent any such meeting.]

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SOCIAL SECURITY AMENDMENTS OF 1983

(Public Law 98-21)

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CONFORMING AMENDMENTS

SEC. 602. (a) * * *

(h)(1) Section 1878(a) of such Act is amended—

(A) by inserting "and (except as provided in subsection (g)(2)) any hospital which receives payments in amounts computed under subsection (b) or (d) of section 1886 and which has submitted such reports within such time as the Secretary may require in order to make payment under such section may obtain a hearing with respect to such payment by the Board" after "subsection (h)" in the matter before paragraph (1),

(B) by inserting "(i)" after "(A)" in paragraph (1)(A),

(C) by inserting "or" at the end of paragraph (1)(A) and by adding after such paragraph the following new clause:

"(ii) is dissatisfied with a final determination of the Secretary as to the amount of the payment under subsection (b) or (d) of section 1886,", and

(D) by striking out "(1)(A)" in paragraph (3) and inserting in lieu thereof "(1)(A)(i), or with respect to appeals under paragraph (1)(A)(ii), 180 days after notice of the Secretary's final determination,".

(2)(A) The last sentence of section 1878(f)(1) of the Social Security Act is amended by inserting "(or, in an action brought jointly by several providers, the judicial district in which the greatest number of such providers are located)" after "the judicial district in which the provider is located".

(B) Section 1878(f)(1) of such Act is further amended by adding at the end thereof the following new sentence: "Any appeal to the Board or action for judicial review by providers which are under common ownership or control must be brought by such providers as a group with respect to any matter involving an issue common to such providers.".

(C) Notwithstanding section 604, the amendments made by this paragraph shall be effective with respect to any appeal or action brought on or after April 20, 1983.

(3) Section 1878(g) of such Act is amended by inserting "(1)" after "(g)" and by adding at the end of the following new paragraph:

"(2) The determinations and other decisions described in section 1886(d)(7) shall not be reviewed by the Board or by any court pursuant to an action brought under subsection (f) or otherwise."

(4) The third sentence of section 1878(h) of such Act is amended by striking out "cost reimbursement" and inserting in lieu thereof "payment of providers of services".

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INTERNAL REVENUE CODE

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Subtitle C—Employment Taxes

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CHAPTER 23—FEDERAL UNEMPLOYMENT TAX ACT

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SEC. 3304. APPROVAL OF STATE LAWS.

(a) REQUIREMENTS.—The Secretary of Labor shall approve any State law submitted to him, within 30 days of such submission, which he finds provides that—

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(4) all money withdrawn from the unemployment fund of the State shall be used solely in the payment of unemployment compensation, exclusive of expenses of administration, and for refunds of sums erroneously paid into such fund and refunds paid in accordance with the provisions of section 3305(b); except that—

(A) an amount equal to the amount of employee payments into the unemployment fund of a State may be used in the payment of cash benefits to individuals with respect to their disability, exclusive of expenses of administration;

(B) the amounts specified by section 903(c)(2) of the Social Security Act may, subject to the conditions prescribed in such section, be used for expenses incurred by the State for administration of its unemployment compensation law and public employment offices; and

(C) nothing in this paragraph shall be construed to prohibit deducting an amount from unemployment compensation otherwise payable to an individual and using the amount so deducted to pay for health insurance *or health care* if the individual elected to have such deduction made and such deduction was made under a program approved by the Secretary of Labor *or a contribution amount under section 2008 of the Social Security Act.*

* * * * * * *

(17) any interest required to be paid on advances under title XII of the Social Security Act shall be paid in a timely manner and shall not be paid, directly or indirectly (by an equivalent reduction in State unemployment taxes or otherwise) by such State from amounts in such State's unemployment fund; [and]

(18) if the State establishes a program under section 2008 of the Social Security Act, the State agency administering the State unemployment compensation law shall carry out the functions required of it under such section; and

[(18)] *(19)* all the rights, privileges, or immunities conferred by such law or by acts done pursuant thereto shall exist subject to the power of the legislature to amend or repeal such law at any time.

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Subtitle D—Miscellaneous Excise Taxes

[CHAPTER 41—PUBLIC CHARITIES]

CHAPTER 41—PUBLIC CHARITIES: CERTAIN HEALTH PLANS OF LARGE EMPLOYERS

Subchapter A. Public charities.
Subchapter B. Health plans of large employers which do not meet open enrollment requirements for spouses of the unemployed.

Subchapter A—Public Charities

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Subchapter B—Health Plans of Large Employers Which Do Not Meet Open Enrollment Requirements for Spouses of the Unemployed

Sec. 4912. Tax on health plans of large employers which do not meet open enrollment requirements for spouses of the unemployed.

SEC. 4912. TAX ON HEALTH PLANS OF LARGE EMPLOYERS WHICH DO NOT MEET OPEN ENROLLMENT REQUIREMENTS FOR SPOUSES OF THE UNEMPLOYED.

(a) TAX IMPOSED.—In the case of a large employer, there is hereby imposed for each taxable year a tax equal to—

(1) $500, multiplied by

(2) the aggregate number of failures to meet the requirements of subsection (b) during such taxable year under any group health plans offered by such employer.

(b) OPEN ENROLLMENT PERIOD.—

(1) IN GENERAL.—A group health plan meets the requirements of this subsection only if it provides a qualified open enrollment period for each married employee—

(A) who is (or at a previous time was) eligible to enroll or is enrolled under the plan, and

(B) whose spouse loses eligibility for coverage under a group health plan due to the involuntary layoff or involuntary separation (other than for cause or mandatory retirement) from the spouse's employment.

(2) TERMS AND CONDITIONS SAME AS FOR ENROLLMENTS FOR NEW EMPLOYEES.—

(A) IN GENERAL.—The terms and conditions of an enrollment during a qualified open enrollment period shall be the same as the terms and conditions which would be offered by the group health plan to the married employee described in paragraph (1) if such employee began employment for the employer on the first day of such period.

(B) EMPLOYEES ALREADY COVERED MAY NOT INCREASE LEVEL OF BENEFITS.—In the case of an employee who is covered under a group health plan before the qualified enrollment period, subparagraph (A) shall not require a group health plan to allow such individual to elect a higher level of benefits than that provided by such coverage.

(C) COMMENCEMENT OF COVERAGE.—Any enrollment during a qualified open enrollment period need not take effect before the date on which the loss of coverage described in paragraph (1)(B) takes effect.

(c) DEFINITIONS; NONTAXABLE ENTITIES.—For purposes of this section—

(1) QUALIFIED OPEN ENROLLMENT PERIOD.—For purposes of this paragraph, the term "qualified open enrollment period" means the 30-day period beginning on the day on which an appropriate State agency notifies the spouse of a married employee described in subsection (b)(1) that such spouse has become eligible for receipt of unemployment compensation under any Federal or State law by reason of the separation or layoff described in subsection (b)(1)(B).

(2) LARGE EMPLOYER.—The term "large employer" means an employer who, on each of some 20 days during the calendar year or the preceding calendar year, each day being in a different calendar week, employed for some portion of the day 10 or more individuals.

(3) EMPLOYER.—The term "employer" does not include the Government of the United States, the government of the District of Columbia or any territory or possession of the United States, a State or any political subdivision thereof, or any agency or instrumentality (including the United States Postal Service and Postal Rate Commission) of any of the foregoing, except that such term includes nonappropriated fund instrumentalities of the Government of the United States.

(4) GROUP HEALTH PLAN.—The term "group health plan" has the meaning given such term by section 162(i)(2).

(5) NONTAXABLE ENTITIES.—In the case of a large employer who is not subject to tax under this title, the calendar year shall be treated as such employer's taxable year.

(d)) CROSS REFERENCES.—

(1) For provision denying deduction for tax imposed by this section, see section 275(a)(6).

(2) For provisions making deficiency procedures applicable to tax imposed by this section, see section 6211 et seq.

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Subtitle F—Procedure and Administration

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CHAPTER 61—INFORMATION AND RETURNS

Subchapter B—Miscellaneous Provisions

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SEC. 6104. PUBLICITY OF INFORMATION REQUIRED FROM CERTAIN EXEMPT ORGANIZATIONS AND CERTAIN TRUSTS.

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(c) PUBLICATION TO STATE OFFICIALS.—

(1) GENERAL RULE.—In the case of any organization which is described in section 501(c)(3) and exempt from taxation under section 501(a), or has applied under section 508(a) for recognition as an organization described in section 501(c)(3), the Secretary at such times and in such manner as he may by regulations prescribe shall—

(A) notify the appropriate State officer of a refusal to recognize such organization as an organization described in section 501(c)(3), or of the operation of such organization in a manner which does not meet, or no longer meets, the requirements of its exemption,

(B) notify the appropriate State officer of the mailing of a notice of deficiency of tax imposed under section 507 [or

chapter 41 or 42], *subchapter A of chapter 41, or chapter 42*, and

(C) at the request of such appropriate State officer, make available for inspection and copying such returns, filed statements, records, reports, and other information, relating to a determination under subparagraph (A) or (B) as are relevant to any determination under State law.

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United States Code

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TITLE 5—GOVERNMENT ORGANIZATION AND EMPLOYEES

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SEC. 5315. POSITIONS AT LEVEL IV.

Administrator of the Health Care Financing Administration.

VI. Additional Views on S. 951, Health Benefits for the Unemployed

The Finance Committee on July 13 completed action on S. 951, Health Benefits for the Unemployed. We had hoped to report to our constituents that we supported legislation that would provide urgently needed health care coverage to unemployed Americans. Unfortunately we can only report that the Committee chose to reward one needy group, the unemployed, at the expense of an equally distressed group, the elderly.

The legislation as originally proposed, S. 951, was designed to provide sorely needed health benefits to those who have become unemployed as a result of our nation's deepest economic slump since the Great Depression. No one questions the need for this assistance. However, we did not expect that these benefits would be provided at the expense of the elderly. Indeed, the budget resolution permits spending of more than twice the cost of the Committee's program without cutting other programs to finance health benefits for the unemployed. We are therefore deeply disappointed that the Committee chose to require our older Americans to foot the bill for the unemployed. Through its cuts in the Medicare program, the aged and disabled will be required to contribute $1.7 billion over the next 3 years to finance health benefits for the unemployed. Specifically, Medicare Part B premiums will be permanently fixed at 25 percent of the full cost and prevailing fees for physician services will be frozen for 1 year. This latter measure may not appear to affect patients but it will clearly result in at least half the aged paying more out of pocket for physician's services and in fewer physicians accepting assignment and merely billing the patient for an additional fee.

It is also important to remember that the health insurance for the unemployed program will last only two years. The elderly are not so fortunate, since their additional costs will continue into the indefinite future.

The Finance Committee action serves as a blow to our senior citizens, one third of whom are already at the poverty level. Older Americans currently pay almost half of their health care costs out of their own pockets and are confronted with double digit health cost inflation over which they have no control. It is ironic that those least able to shoulder the burden are now being asked to sacrifice for the unemployed.

This year, the Administration has proposed almost $2 billion in Medicare cuts, for fiscal year 1984, with 75% of these cuts to be borne by the beneficiaries. With $1.7 billion in Medicare savings being used to finance the Health Benefits for the Unemployed Bill, another $1.8 billion in savings is demanded. This will result in a projected $3.5 billion total, most of which will be borne by the beneficiaries. We note that these planned Medicare cutbacks are

twice as great as are required by the budget resolution. Coupled with the $1.3 billion savings from lower revenue sharing authorizations than provided for in the budget, the Finance Committee plans this year to reduce spending by almost three times the level of budget cuts required by the Budget Resolution.

Much as we would like to vote for legislation to protect the millions of unemployed who need adequate health protection, we refuse to send the bill to our parents. If the program for the unemployed is worth doing—and we believe it is—it's worth paying for—by all of us. We deeply regret that we cannot vote for this bill.

BILL BRADLEY.
SPARK MATSUNAGA.
MAX BAUCUS.
DANIEL PATRICK MOYNIHAN.

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